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MONTREAL
APRIL
1948

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Cancer of the Breast
by R. D. Nash, M.D.

Your Introduction to New Brunswick
by K. B. Carson

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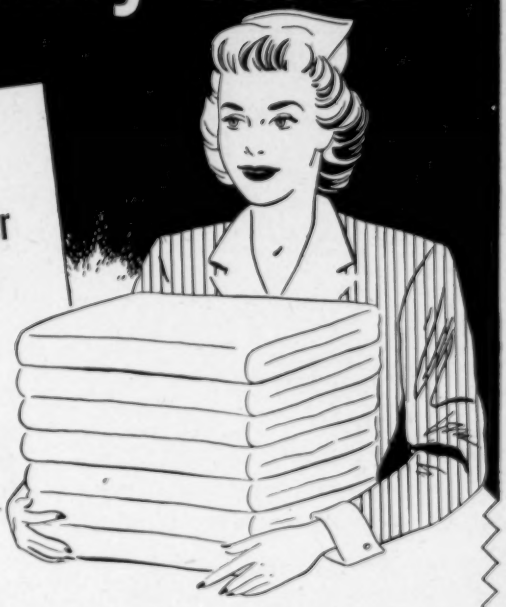

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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MONTREAL CANADA

Between Ourselves

Our guest editor this month, **Lois R. MacDonald,** brings greetings from the Prince Edward Island Registered Nurses Association of which she is president. Though they are a very small group numerically, only 325 at the last report, they are very much alive to the needs of nursing. They take a keen interest in and actively support the various national undertakings. Under Mrs. MacDonald's leadership, many projects are in the offing, as you will see when you read her editorial.

Mrs. MacDonald was born at Wheatley River, P.E.I., of Scottish parentage. She graduated from the Prince Edward Island Hospital, Charlottetown, in 1934 and engaged in private duty for six years. After two years as night supervisor at the P.E.I. Hospital, she enrolled in the course in teaching and supervision in schools of nursing at the University of Toronto, obtaining her certificate in 1943. She was instructor of nurses at Prince County Hospital, Summerside, for three years, going to her alma mater in 1946 as superintendent of nurses.

As might be expected in a native daughter of this lovely province, Mrs. MacDonald's favorite hobby is gardening. We would also suggest to potential nurse visitors to the Island this summer that she is a bridge enthusiast. By all means include a visit to P.E.I. in your summer itinerary. You will be warmly welcomed.

To countless nurses, **New Brunswick** is only a place on the map of Canada or the place where John met his wife when he was in the R.C.A.F. or where the neighbors next door came from. To vitalize this small but exceedingly interesting province in the minds of all nurses and particularly those who will be going to the biennial convention in Sackville, we shall feature human interest accounts in this and two succeeding issues. Through the courtesy of the New Brunswick Government Bureau of Information and Tourist Travel and from other sources, we have secured an abundant supply of photographs with which we will illustrate each article. We miss our guess if you do not feel the lure of this beautiful province.

The amplification of the **programs of the Workshops** planned for this biennial convention, which will be found in Notes from National Office, promises a veritable refresher for the nurse participants. With registration in each Workshop limited to fifty, and only nine Workshops slated, it looks as though the first 450 nurses to send in their preferences, as requested, would have the inside edge on their colleagues. We have been assured, however, that provision will be made for *all* nurses to benefit from this valuable experience, even to the setting-up of additional Workshops if necessary. You can help materially in determining what the need will be by mailing your choices to National Office immediately. Their address: *Suite 401, 1411 Crescent Street, Montreal 25, P.Q.*

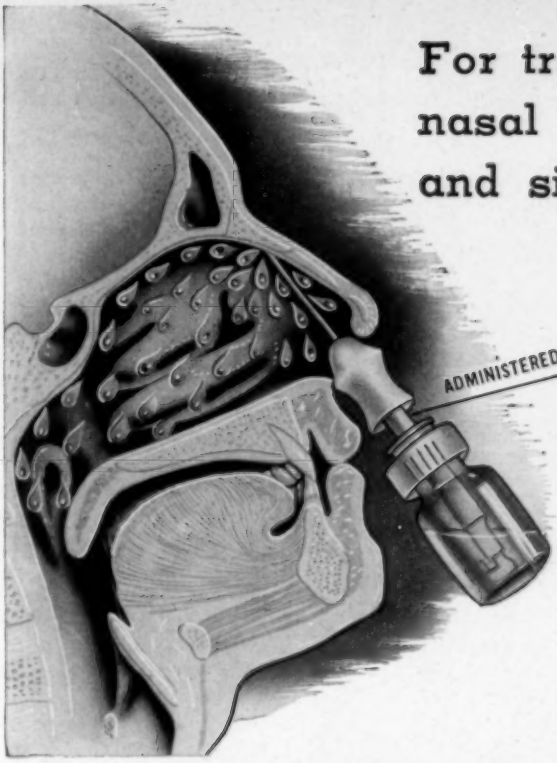
The table of contents this month offers a wide variety of exceedingly pertinent and interesting material. **Dr. Ronald D. Nash** urges every nurse to be fully informed regarding cancer of the breast. More readily discoverable than internal growths, there are still an alarming number of patients who are not seen by their physicians until the growth is well advanced.

Dr. Olive Cole has the unique distinction of being the only feminine orthodontist in Canada. The importance of proper occlusion is emphasized because of its psychological effect as well as the physical appearance. The condition of the mouth plays a vital part in the individual's social adjustment

There is stimulating hope for the paraplegics, the arthritics, etc., in the new program which has been embarked upon by the Montreal Branch of the Victorian Order of Nurses. **Christine Livingston** interprets this for us. An outgrowth of this work since the article was written is the sanction for the appointment of a full-time physiotherapist to the Montreal Branch to augment the instruction presently being given by the nursing staff.

Occasionally two authors will submit valuable articles on the same topic simultaneously. That happened with the material on **Addison's disease.** The two cases presented so many different points that we decided to summarize their introductory materials and give you both aspects at the same time.

We are grateful to the subscribers who wrote us establishing the identity of the author of "Pioneer Nursing" (February, 1948) as **Mary Ellen Birtles.** Miss Birtles was superintendent of nurses of the Brandon General Hospital, Man., for twenty-one years. She retired in 1919. Throughout her long professional career, and even in the years of her retirement, she retained a lively interest in nursing affairs. Miss Birtles passed away in 1943.



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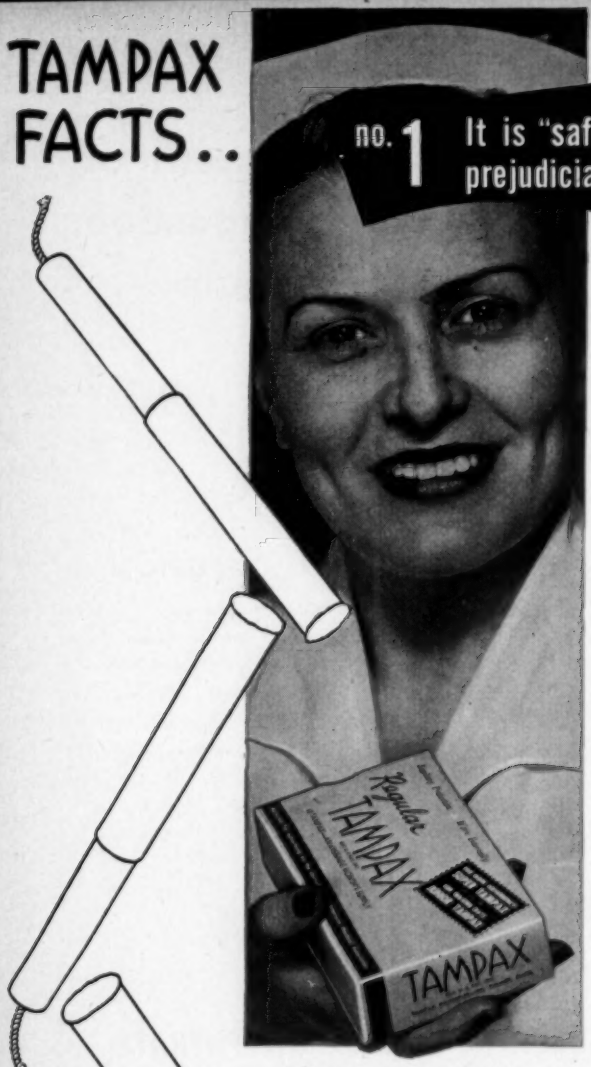

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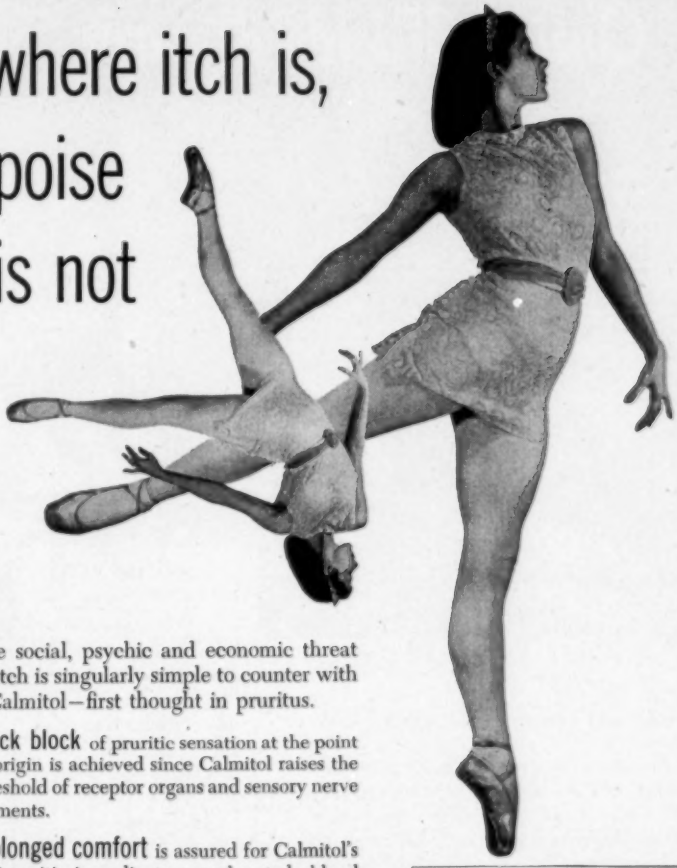

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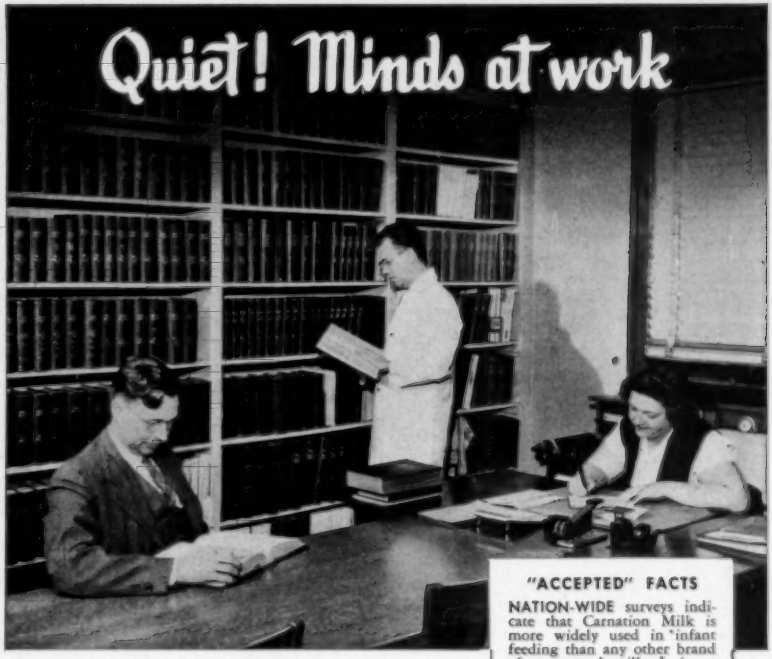

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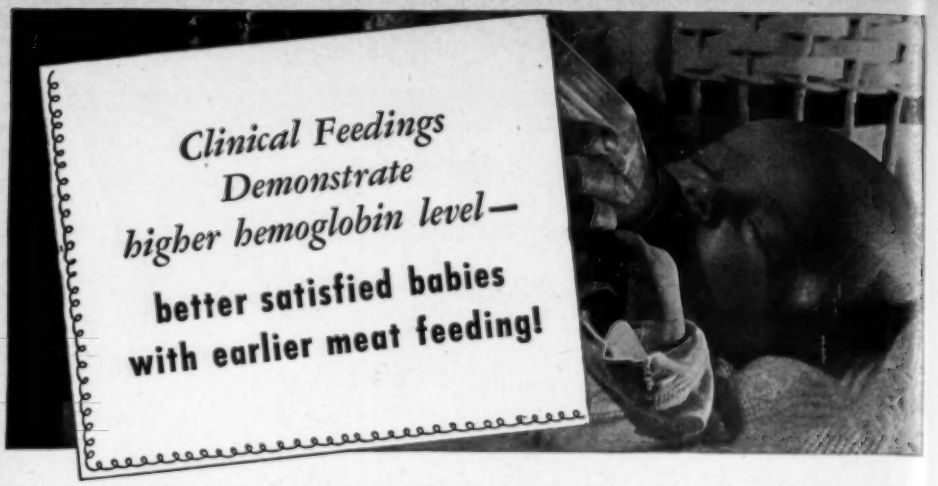

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**MEAT IN THE DIET OF YOUNG INFANTS*
Ruth M. Leverton, Ph.D. and George Clark, M.D.
J. A. M. A. 134:1215 August 9, 1947

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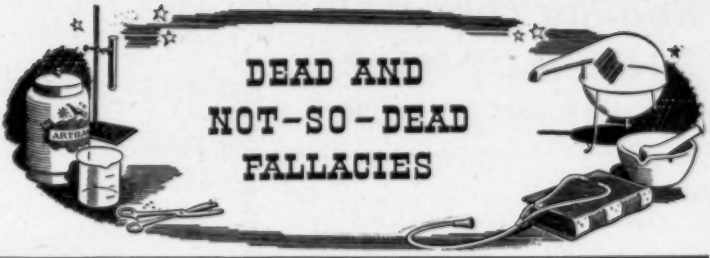

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-FOUR *NUMBER FOUR*

MONTREAL, APRIL, 1948

Prince Edward Island

THE MICMACS called it Abegweit; to the French it was Isle St. Jean; and at about the end of the eighteenth century it was given the name it now bears—Prince Edward Island. It has had to live up to such flowery titles as "The Garden of the Gulf" and "The Million-Acre Farm." To our own people, however, it has always been "The Island," as we all happily say, "What other island is there?"

Our population is not large—some ninety-five thousand—with over 80 per cent of British extraction, nearly half of whom are of Scottish descent. Three-quarters of our people live in the rural areas of the province. Thus agriculture is our predominant occupation.

As we, in the nursing profession in Prince Edward Island, look back over the past quarter of a century we feel that much progress has been made in nursing education. We are not unconscious of the disappointments and difficulties encountered by being a small island province with a small provincial association. The war is over; we graduate more nurses each year; we try to prepare more people to fill executive positions; and yet the number available to maintain a desirable nursing service and give adequate nursing care is still below our needs. Hospital facilities are expanding rapidly and teaching departments are greatly improved. Our hopes are high for a greater number of nurses for general duty and an increased student enrolment.

In nursing education we are keenly aware of the "trends." Attempts are

LOIS MACDONALD

being made to raise and maintain the standards of entrance into schools of nursing in Prince Edward Island comparable with those of the other provinces of Canada. We feel that we will be benefitting the professional nurses of tomorrow by so doing. The Legislation Committee is giving much thought and time to the study of this problem. Recently, a series of talks was given to the high school girls in an endeavor to demonstrate the value of higher education before entering the nursing field. For some time, the need of a school of nursing adviser has been felt, and now plans are being made to try to obtain a fully qualified person for this position.

We have taken yet another step towards standardizing nursing education in Prince Edward Island. An instructors' group has been organized and, though still in its infancy, we look forward to the establishment of a greater uniformity in course outlines, standards of teaching, and testing throughout the province.

The trained attendant, nurses' aide or practical nurse is receiving considerable attention at present. These attendant nurses have been graduated from several institutions during the past years and recently we have had another group graduated from a third institution under the Department of Health and Welfare. At this time there is a sizable number of these trained attendants in the province, and as yet they have no act to define their duties and limitations or to give them protection and security. Studies are being made and plans are being formulated for this purpose.

With the end of 1947, public health nursing celebrated its twenty-fifth year of organized effort in the island province. From one nurse to eight in that period of time is not very rapid growth, but the foundation is solid. An awareness of health matters and a demand for increased service is apparent on the part of the public, so one feels that health education is definitely in the ascendancy. How the much-needed expansion will materialize against the general shortage and attraction of more lucrative fields is difficult to foretell; but since hope continues to spring eternal, the small group plods on, always adding something new and fresh to bolster up its varied program.

Since this year the biennial meeting of the Canadian Nurses' Association is being held in Sackville, N.B., our neighboring province, we hope many of the members will avail themselves of the opportunity of visiting our island. Historically, we have much of interest, including the Provincial Buildings where the Fathers of Confederation assembled to complete the historic union of the provinces and the Dominion of Canada was born. The Prince Edward Island Registered Nurses Association is small, but each of us extends a very cordial invitation to all.

LOIS R. MACDONALD
President
Prince Edward Island
Registered Nurses Association

Dates to Remember

April 15-16—Manitoba Association of Registered Nurses at Fort Garry Hotel, Winnipeg.

April 22-24—Registered Nurses Association of Ontario at Royal York Hotel, Toronto.

May 2—Nurses' National Memorial Vesper Services.

May 26-28—Association of Nurses of the Province of Quebec at Windsor Hotel, Montreal.

June 10-11—Registered Nurses' Association of Nova Scotia at Antigonish.

June 17-19—Canadian Society of Radiological Technicians at Chateau Frontenac, Quebec.

June 28-July 1—Canadian Nurses' Association at Mt. Allison University, Sackville, N.B.

Cancer of the Breast

RONALD D. NASH, M.D.

CANCER in any form commands respect, rather than fear. It is not unlike a person standing in the path of an oncoming truck. If he or she sees the truck early enough there is an excellent chance of not getting injured or killed. If, however, the person is not on the look-out, because of ignorance or fear, the chances of escape are accordingly lessened.

Public education in the early symptoms and signs of cancer is one of the major medical problems of the day. The treatment of any cancer is limited in its scope. Early, much can be done in most types and the cure rates are high; but not so in the more advanced cases, when the cancer cells have spread from the primary lesion throughout the whole body.

The nursing profession can perform an excellent service in the transfer of such knowledge to the public. If the thousands of nurses in this country could become conversant with these early symptoms and signs of the more common cancers, they could do much to spread such knowledge through the circle of laymen in their community. This could be done quite easily among their friends in everyday life.

Ignorance and fear on the part of the public are two of the best friends which cancer has today. There is little excuse for ignorance, if every means is used to educate the public in these matters. The fear of the disease could in this way be converted into respect. This is our problem. The sooner we complete this job, the sooner cancer will be a second-rate threat to humanity. The nursing profession can do much to expedite this work.

GENERAL

Carcinoma of the female breast rates with similar lesions on the skin, lips, and tongue, in that it can usually be diagnosed quite early in its course. There is no reasonable excuse for the so-frequently advanced lesions seen by the family physician for the first time, and yet, daily throughout the country, these are being seen literally by the hundreds of cases.

Cancer of the breast occurs more frequently in women who have not borne children, which is in contrast to the other common malignant tumors in women. It appears most frequently at or near the menopause, but is *not* common in the twenties nor the sixties.

ETIOLOGY

The etiology of cancer is not clear, and carcinoma of the breast does not differ in this respect. The disease can be propagated quite easily in some

Dr. Nash graduated in medicine from the University of Toronto in 1941. Following a year at St. Michael's Hospital he joined the R.C.A.F., serving as x-ray specialist in various base hospitals in Canada, Alaska, and Newfoundland. From the R.C.A.F. he went to the x-ray department at the Kingston General Hospital. While in Kingston he received the Kinsmen Scholarship and continued his studies in radiology under Dr. R. C. Burr, director of the Kingston Cancer Clinic, for a period of six months as part of the three-year course under the scholarship. From Kingston he went to the Royal Victoria Hospital, Montreal, and studied pathology under Dr. Lyman Duff for six months. At the present time Dr. Nash is studying under Professor Mayneord at the University of London and Royal Free Cancer Hospital, London, England.

DR. RONALD D. NASH

strains of rats and mice, and much interesting work has been done in this field. Heredity, which appears to play an important part in this disease in animals, does not seem to be a noteworthy factor in humans. Ovarian overstimulation by means of hormones may be of importance. Trauma and external irritation are *not* direct causative factors. We do know that the younger the individual, the more rapidly growing the lesion is, generally. We also know that carcinoma of the breast seems to flourish during pregnancy.

Pathology

Briefly, there are several types of carcinoma of the mammary gland. Of these, the scirrhus and the medullary carcinomas are the commonest. The former consists of a preponderance of fibrous tissue in comparison with the number of tumor cells; in the latter, this relationship is reversed. The scirrhus is the slower growing of the two, but spreads early. The medullary type grows very rapidly, and the course of the disease is comparatively short.

Duct carcinoma and adenocarcinoma of the breast are fairly rare. Paget's disease of the mammary gland, however, deserves mention. This appears as an intractable eczema of, and about, the nipple, which fails to respond satisfactorily to any treatment. Its course is progressive and is usually followed by the development of cancer of the breast in a few years.

Signs and Symptoms

Early, the first sign of a tumor is the presence of a "lump," which is usually not tender and which gradually and slowly increases in size. As the tumor expands, it may become fixed by its extension to the overlying skin or to the chest wall posteriorly. The skin may eventually ulcerate or show a dimpling or an "orange skin" appearance. If the lump is near the nipple the latter may be retracted or displaced asymmetrically and there may be a slight bloody discharge from the nipple, with or without pressure.

A main characteristic of any cancer is the tendency to spread to other parts of the body. Cancer of the breast is no exception. The size of the tumor does not necessarily determine the number and extent of the metastases. A small, and very early lesion may on occasion cause its first symptoms by the presence of a secondary lesion elsewhere in the body, while a large tumor of long standing may be comparatively innocent in this respect. They are all highly unpredictable.

The cancer cells spread from the primary lesion by way of: (1) direct continuity; (2) lymph channels; (3) the bloodstream.

The earliest secondary lesions are usually found in the regional lymph nodes of the axilla, supra-clavicular and infra-clavicular areas. If not checked, the disease will spread further and may involve the lungs, pleura, bones, brain, liver, skin, etc.

Clinical Diagnosis

The "lump" is the first sign of the growth. This is usually palpated best with the palm of the hand, *not by squeezing*. It is, as stated, usually not tender and grows steadily in size.

The presence of palpable enlarged regional lymph nodes, together with such a "lump," may be due to inflammation or to cancerous spread. Only the pathologist can tell which with certainty. On the other hand, the absence of palpable nodes *does not* necessarily mean that they are not playing host to secondary lesions. This is not fully appreciated by a great many surgeons.

Differential Diagnosis

There are other lesions which may be confused with carcinoma of the breast. Chronic mastitis, however, offers the most difficulty in the differentiation from cancer, mainly because the former is fairly common. It occurs more frequently in women who have had several children. The lumps may be multiple in one or both breasts, are usually tender and painful, more so at the menstrual period.

A clinical examination is not enough.

All persons concerned must appreciate that chronic mastitis can be definitely differentiated from cancer only by the pathologist, after removal of the whole breast or a large portion of tissue, including the nodule or mass of abnormal tissue.

Treatment

First of all, treatment of a patient with a suspected or proven cancerous breast should not be attempted until a complete examination has been carried out, together with an x-ray of the chest and of all the bones of the body commonly involved in secondary lesions. If these are present, the treatment will have to be modified accordingly. If a secondary spread has already taken place, an extensive operation on the primary lesion is of little use.

The principal methods at hand to treat a cancerous lesion are surgery and x-ray or radium therapy. Sound judgment should be applied in their application. We may classify the lesions in three groups:

Group 1. Where there are no metastases from the primary lesion demonstrable clinically or by x-ray.

Group 2. Where there are palpable regional lymph nodes only, associated with the primary lesion.

Group 3. Which includes anything beyond Group 2, that is, involvement of the skin, bones, lungs, etc.

In Groups 1 and 2 the breast and its included tumor should be removed by means of a radical operation by a skilled surgeon. This will include the removal of the involved breast, the underlying fascia and muscles, together with careful dissection and complete removal of all axillary, supra-, and infra-clavicular lymph nodes. Any operation for cases in Group 1 and 2, which does not include all of the above-mentioned tissues, is generally considered an inadequate type of treatment.

Although there is still some debate regarding the advantages of x-irradiation in the treatment of these groups, in this country, Roentgen therapy is generally used also. The mode of action of x-rays on tissue is complicated but, in general, proper doses of x-irradiation will kill an appreciable number of remaining stray cancer cells, cause others to become incapable of reproduction and propagation, induce obliteration of lymph and vascular channels, thus causing poor nutrition and incarceration of other malignant cells.

Some clinics use irradiation preoperatively over the breast and regional nodes; others apply it postoperatively, while some use both methods. However, the most popular method in this country is to give an extensive course of treatment with high voltage x-rays, beginning soon after operation, at most within two to three weeks post-operatively.

The x-ray treatments themselves are painless (contrary to the usual public opinion) but some patients may have some nausea, vomiting, and headache. These symptoms can usually be controlled by medication, or by reducing the amount of daily irradiation. In time, during the treatment series, which will require daily doses for between four and six weeks, the skin becomes quite red over the treated areas. When the treatments are administered by an experienced specialist in this field, and the patient, nurse, and all others carefully follow out his instructions, the skin will eventually return to quite normal texture.

In the cases of Group 3, the treatment, whether it be x-ray or surgery or a combination of both methods, is usually only palliative. Still, much can be done to prolong the life and increase the comfort of the patient. Occasionally, a clinically advanced case will live four to five years, which means a gain of two to three years as compared to an untreated case. In this group, a simple removal of the breast only is justified, either before or after x-ray treatment, to prevent ulceration and unpleasant slough of the primary tumor. Artificially radioactive substances (radio-active isotopes) have not been of any value as yet in the treatment of primary lesions in these cases.

Follow-up

Of importance equal to the selection of the proper combination of surgery and irradiation for the primary tumor is the follow-up treatment of these patients subsequent to their operation and x-ray therapy. They should be seen and examined by their clinician or at a clinic, at frequent, scheduled intervals for at least ten years, if not longer. A very suitable plan is the following: first year, every three months; second year, every six months; then yearly, unless the patient has some complaint.

It is important that the patient be convinced of the necessity of such visits. Some will appear promptly for two or three years, but then, because of lack of symptoms, they cease to come in for further check-ups. It is known, however, that secondary lesions may appear as long as twenty years after the primary lesion has been treated and apparently controlled with no secondary symptoms. Such a follow-up need not cause the patient any worry, but it should be repeatedly impressed upon her that "we would like to see you at frequent intervals to see how you are getting along."

At these follow-up examinations a thorough interval history should be taken, and a physical examination should be carried out. Any weight loss, headaches, chest, back, or joint complaints should be inquired into. Periodically, an x-ray of the chest should be taken, especially at the time of any unexplained chest complaint. Bones and joints should be x-rayed especially if she complains of constant or recurrent local pain suggestive of a metastatic lesion. All of this is done to detect early any possible secondary manifestations of the disease, and to afford the patient as much security of life, or as much comfort and usefulness as possible.

Lesions in the bones respond quite readily to further x-ray treatments over the involved areas, with complete relief of pain. Metastases in the lungs, pleura, brain, and liver do not give such a response to deep x-ray. There is, however, the possibility that the artificial radio-active isotopes will be of value in these manifestations. To a certain degree they are of benefit in bone lesions at present.

Castration, either surgically or radiologically, does not prevent the tumor from spreading, but seems to induce some relief to a majority of patients with secondary bone lesions. It is thought to effect some relief in about 50 per cent of cases with secondary lung and pleural lesions. Another and perhaps more real advantage of castration is to prevent pregnancy with its almost fulminating effect on the growth and dispersion of a breast cancer and its attendant danger to both mother and potential child.

Treatment Complications

Following the operation, the skin at the site of operation may feel slightly tight. Occasionally there may also be a slight weakness and limitation of movement of the shoulder joint.

In some cases, about a year after the operation, there may be some swelling of the arm on the involved side due to the disturbance of the lymph drainage channels. Usually, when it does occur, in about 30 per cent of the patients, it is only very slight in amount, but in very infrequent cases the patient has a greatly swollen edematous arm.

Unfortunately, there is very little treatment for such a complication. Proper instruction of the patient in ways and means to assist the lymph drainage by improving the posture, exercise, and some gentle massage will greatly improve the situation. If a residual or recurrent tumor is the cause, further irradiation may be used. Sometimes, however, this may spontaneously subside, completely or in part, in a few months.

Conclusion

No attempt has been made to outline in every detail the entire course of cancer of the breast, but only to give a few of the current ideas on the subject. The nurses of this country, both active and retired, should be-

come familiar with some of the main aspects o cancer, and especially with the early signs and symptoms and the general plan of trea ment. They should be able to discuss with non-medical people the current ideas on this subject as much as possible.

Cancer of the breast offers an opportunity for them to aid the medical profession in the attempt to educate the public on this subject; to teach women the importance of the "lump," of frequent examination of their breasts, and the respect that such lumps command. The intelligent nurse can do much to dispel the fear of her fellow-women, to encourage them to consult experienced family physicians and specialists early, and to point out that many women, even with metastases, when properly treated, have been able to carry on useful lives in relative comfort for many years.

Acknowledgement: I wish to express my sincere appreciation to Dr. Carleton B. Peirce, Radiologist-in-Chief, at the Royal Victoria Hospital, Montreal, for his help in preparing this paper.

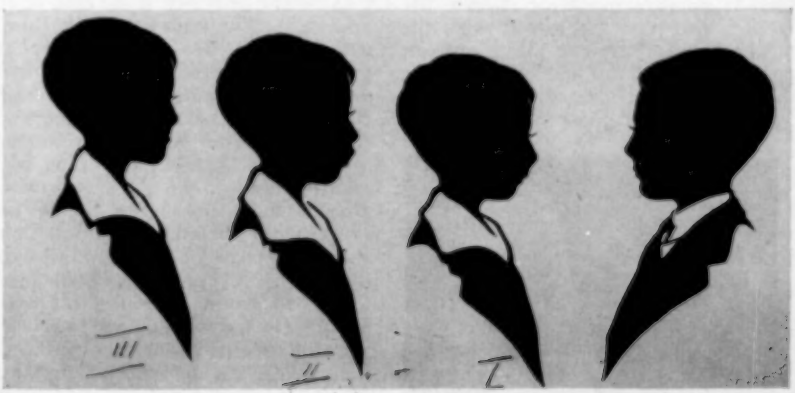
Orthodontia

L. Olive Cole, D.D.S.

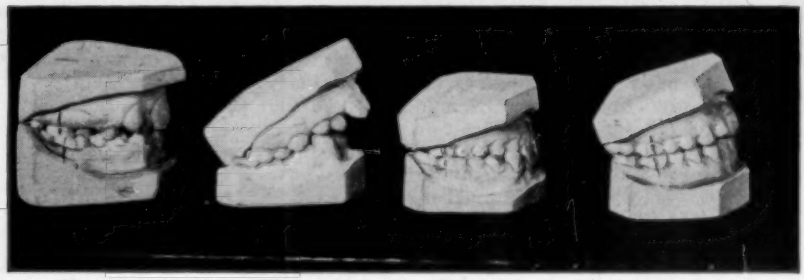
Dentistry, like medicine and nursing, is one of the healing arts. Orthodontia is a specialized branch of dentistry, dealing with the correction of malformed and malposed jaws, and straightening crooked teeth to get normal occlusion. Straightening crooked teeth is really the means to the end—correcting jaw deformities, by getting a normal working bite.

There are three distinct types of malocclusion. In Class 1, both upper and lower jaws are underdeveloped, the teeth are very irregular, and do not occlude normally. Often several of the uppers are lingual of the lowers. It is a case of some hit, others miss, so all are abused; some getting the full force of the bite, others no force at all, which is quite as bad, for they are soon lost. The body soon gets

Dr. Cole has the distinction of being the only lady orthodontist in Canada. She lives in Winnipeg.



Profiles of 3 classes of deformities and the normal



Class 1 *Class 2* *Class 3* *Normal*

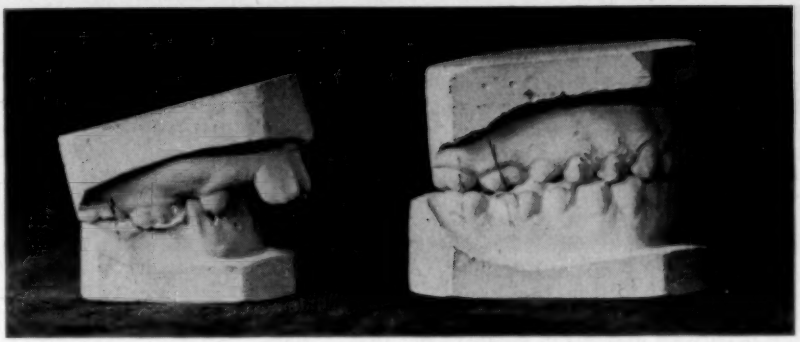
rid of anything that is useless, and overwork destroys the rest. The profile tells the story, for the lower half of the face is out of proportion to the upper. It is babyish and weak-looking by comparison, for the upper half develops normally and the lower does not.

The cause is generally the too early loss of temporary teeth so that the space needed for the permanent tooth replacing each one lost has been taken by a permanent tooth erupting earlier. If the baby teeth are retained till the normal time of loss, each permanent tooth has to wedge itself into the jaw, and this wedging in brings about the normal growth of the jaw. Sometimes the baby teeth are retained too long. The erupting permanent tooth absorbs the roots of the temporary tooth unevenly, so that it is not guided into place evenly. The absorbing roots give it a lingual or labial inclination, and it appears inside or outside the arch. You have all seen it with the lower incisors. If the lower centrals are not out at the age of seven, the permanent centrals are usually to be seen appearing behind the baby teeth.

Class 2: With labial frenum

Class 2 is the ugliest type, with overdeveloped upper jaw, and protruding upper teeth, often widely spaced and at a queer outward slant. The lower jaw is noticeably small and set too far back. Sometimes the lower front teeth even bite into the upper soft palate, a half inch or more behind the upper incisors, and the child seems to have no chin at all. The profile is distressingly ugly. A comedy type—these so-called "buck-teeth"—to all but the one so deformed.

Of the three types, this is the one most frequently attributed to heredity. You can often see the same deformity in the mother, or else you hear the story of father or grandparents having the same defect. Bad habits are the other contributing cause—thumb or finger-sucking seems to be the worst. Thumb-sucking, in particular, pulls the upper front teeth forward to the protruding angle, making the bone below the nose heavy and ugly. The knuckle of the thumb generally pushes hard against the tiny chin, stopping its development and really pushing the jaw distally, thus making the angle of the jaw a right or even an acute angle, instead of the long obtuse angle that is so greatly admired in a lovely jaw. I never see a tiny baby busily and contentedly sucking its thumb but I see ahead years of correction, for this is the hardest type to correct and even harder to retain afterward. The deformity is noticeable very early. If the child begins to suck its thumb the first month, the deformity is apparent in two or three months and grows progressively worse as long as the



Class 2: With labial frenum

habit continues. It is no wonder, for the force is very great, as you will find out for yourself if you attempt to remove the thumb from the infant's mouth.

Even after the habit is stopped, if the deformity has reached the stage where the upper teeth rest on the lower lip, the lip muscles continue the protrusion of the upper front teeth and the deformity gets worse. Orthodontia treatment is needed, the earlier the better—at eight or nine years is best. Treatment is so often not undertaken until the patients are earning. Then they come anxiously asking if anything can be done for them, often at eighteen, or even in their twenties and thirties. This type always has such a marked inferiority complex because of the deformity that it is a handicap, both socially and in business. I have had employers enquire if it can be corrected for some valued employee who could go further if the deformity and complex could be removed.

More orthodontia for adults has been performed in the last few years than ever before and patients find it decidedly worthwhile. Correction saves the teeth and promotes mouth health. None of the protruding front teeth are able to do any work, for they do not occlude with teeth in the opposing jaw and they soon become diseased because of lack of work. Class 2 is particularly prone to pyorrhea and the consequent early loss of teeth.

In Class 3, the upper arch is underdeveloped and held back because it is encircled by the overdeveloped lowers. The lower jaw is massive and every closure of the mouth irritates it to greater growth. This type cannot chew! He can only *chop* his food, for there is no side movement of the jaws as the upper jaw is locked in. It is almost always the medical man who sends a Class 3 individual to the orthodontist, for the patient is nervous, underweight, and has digestive troubles, and the doctor, who has been hunting for the cause, suspects malocclusion.

Luckily, the Class 3 type can be more quickly corrected than the others. However, the bite has to be opened to get the uppers up and out of their malposition. Once the correction is completed, there is a slow but steady growth of the abnormally small upper jaw and an immediate improvement in the patient's general health. At last he can really chew and he enjoys eating the very foods that had caused the greatest digestive disturbance, because the food is no longer bolted but can be properly chewed before swallowing.

Class 3 malocclusion should be corrected, at the earliest, at six or seven years if the baby teeth are so malposed, or immediately the permanent teeth become inclined towards the deformity. Often, with the permanent teeth, disfigurement begins with just one tooth as it erupts. A long course of treatment can be avoided by having

the position of that tooth corrected before it is fully in place.

One can always tell if a person needs orthodontia by looking at the profile. The "line of beauty" is the artist's standard and can be ours. It is the straight line from forehead to the tip of the chin. If the chin is forward or back of that line, there is something wrong—abnormal. Note the balance of the face development. The lower face from tip of nose to tip of chin is the same length as from tip of nose to hair-line in a perfect face. If the lower half is babyish and out of balance, or if there is a depression under the lower lip which tends to shorten the lower half of the face, these are all signs, by which one can read at a glance, that orthodontia is needed, without even looking inside the mouth. With Class 3 type, the lower face is too heavy and too long—out of proportion.

But the teeth, too, tell the story. If teeth do not occlude normally in a good working bite, and are not all placed in a good strong arch, something should and can be done to correct them, and face balance will improve.

There is one other fault an orthodontist is often asked to correct—the abnormally wide space between the upper centrals, sometimes so wide and ugly that I have been asked if a false tooth could be placed to fill the space. This is caused by the too heavy joining of the two parts of the upper jaw, which close at the centre line, usually above the teeth and just below the inner lip. This labial frenum is sometimes continued down in a heavy muscle between the teeth and attached in a hard knot of muscle tissue behind, almost between, the centrals, keeping them separated. This muscle has to be dissected out, then the centrals can be brought together and held till the bone re-forms to hold them in normal position, otherwise the space gets wider, loosening the contacts of the upper teeth. This defect most frequently appears in Class 2, the upper protruding type.

In the lower jaw, the union is sometimes faulty, too, and then we say the child is tongue-tied. The doctor soon attends to the cutting of that muscle, for the infant generally has trouble sucking, or later has difficulty when he attempts to talk.

The correction of these deformities is a real help to all who have them. Each is a hindrance to perfect mouth health, consequently to general systemic health. When the teeth function properly, the digestive organs are not overworked, attempting to do neglected work. It is also a decided aid to beauty, for deformity is always distressing, particularly to the victim. We need to feel at our best to get the most out of life, and normality in appearance helps to get rid of any inferiority complex that so often prevents us from reaching the point of happiness and success.

"Outpost Hospitals"

There is quiet drama in the motion picture story of the work of the Red Cross hospitals in Canada's frontier districts. The story is simply, though forcefully, told in "Outpost Hospitals," a 16 mm. color film recently completed by Associated Screen Studios, Montreal, for the Canadian Red Cross Society.

This documentary film explains clearly the work the Red Cross has done, the advances made, and tells by implication the need for more workers, more hospitals, and services to those people isolated from larger centres. Starting with the first outpost hospital in Wilberforce, Ont., in 1922, with a nursing staff of one, it traces the growth of this peacetime service of the Red Cross to the present chain of twenty-six hospitals.

The Red Cross nurse in the film is played by Edith Chapman, field supervisor at Ontario Division headquarters, but who once was an outpost hospital nurse. Miss Chapman, who served as technical adviser for "Outpost Hospitals," is shown on duty at the hospitals and visiting the country folk, on call twenty-four hours a day. Travelling by car, by truck, by canoe, by snowshoe or by cutter, she is the only link between modern knowledge and the pioneers who are opening up the Canadian hinterland.

The new film is of particular interest at this time, because of plans for the expansion of the service.

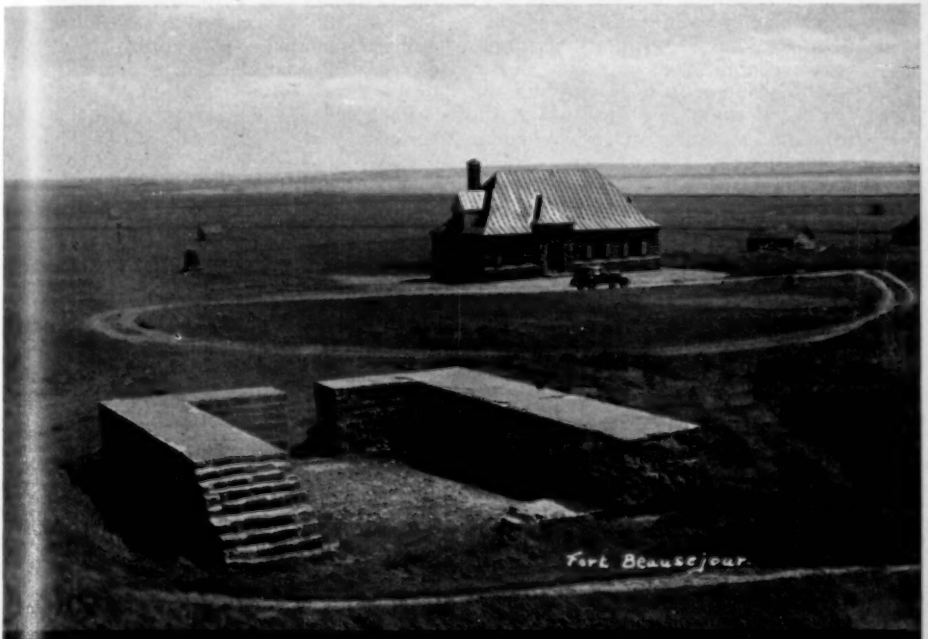
Your Introduction to New Brunswick

K. B. Carson

New Brunswick is the largest Maritime province and is the only one of the three to be solidly attached to the North American mainland. For all of that, New Brunswick still has its front door on the sea, and visitors, in effect, enter the province over the back-stoop of the Maine border or through the side-entrance of the Matapedia.

In many respects, New Brunswick is the most respectable province in Canada. Its constitutional conduct has been almost irreproachable. It has never had any rebels and, indeed, was founded by settlers whose descendants call themselves "loyalists" to this day. New Brunswick achieved representative government, rid itself of a Family Compact and endured the administration of some rather stupid colonial governors without a musket being fired. There is good reason to believe that New Brunswickers of the pre-Confederation era regarded William Lyon Mackenzie, Papineau, and Joseph Howe as thoroughly vulgar fellows.

This sense of proportion is perhaps the principal characteristic of the province. Early history may account for it. New Brunswick was founded by the most remarkable group of settlers who ever entered British North America in a body—the United Empire Loyalists. The Loyalists who



New Brunswick is Rich in Historic Lore

came to Shelburne, on Nova Scotia's south shore, and to Saint John, in what became the province of New Brunswick in 1784, were the leaders of New England's commercial and official life. They despised the revolutionary heroes of the United States to their dying days. A Winslow or a Chipman of New Brunswick regarded John Adams as an upstart and an opportunist, Samuel Adams as a veritable gangster, and Paul Revere as a cunning quisling. History is, after all, a matter of a point of view. The Loyalists, as eighteenth century D.P.'s, had good reason to distrust soap-box orators. Had not so-called 'Liberty' been proclaimed in Massachusetts by a smuggling ring? These circumstances provided New Brunswickers with a unique point of view from the beginning. There wasn't the slighest doubt in the minds of the Loyalists that "the shot heard 'round the world" was fired by a thieving cut-throat.

The Loyalists did not have very much money. They had good manners, good taste, and unusual administrative ability. Early New Brunswick development, was, therefore, not the usual shambling business of the frontier. Under severe economic handicaps the Loyalists created, for that day, a relatively high state of civilization. Moreover, because they had little money, no particular premium was put upon the mere possession of it. Early Loyalist society was a society with a useful sense of human values. Subsequent settlement was regular and orderly until it ceased. Other racial and social groups were absorbed into the firm proportions of the social structure which the Loyalists erected. *The Pattern*, with inevitable but orderly modifications, still persists in New Brunswick life. Not to realize this fact is to miss something most essential to "knowing" the province.

Of course, had not there been subsequent immigration of Scots, Irish, Yorkshiremen, and Pennsylvania Germans, the original Loyalist pattern could have solidified into something rigid and finally comic. As it has happened the modifications have become almost as important as the original. The present-day New Brunswicker takes on the color of a number of racial and social characteristics. A large part of the present population of New Brunswick is not of Loyalist descent at all. There are 150,000 French-Acadians in the province, who have had little and will have less disposition to accept a Loyalist tradition. Scots, Irish, Yorkshiremen and Pennsylvania Germans are certainly all stubborn races, intent upon injecting their own values into any situation. All have made generous contributions to the life and character of New Brunswick as a province.

Yorkshiremen and Pennsylvania Germans followed the Loyalists very closely. The Yorkshire settlement in the Chignecto district still retains its unique character after a century and a half. In some respects the stubborn, creative temper of Yorkshire has been an effective foil to the formalism of the Loyalist in provincial affairs. Mount Allison University, thriving industries, a high level of culture, even on remote Tantramar farms, all testify to the Yorkshire contribution.

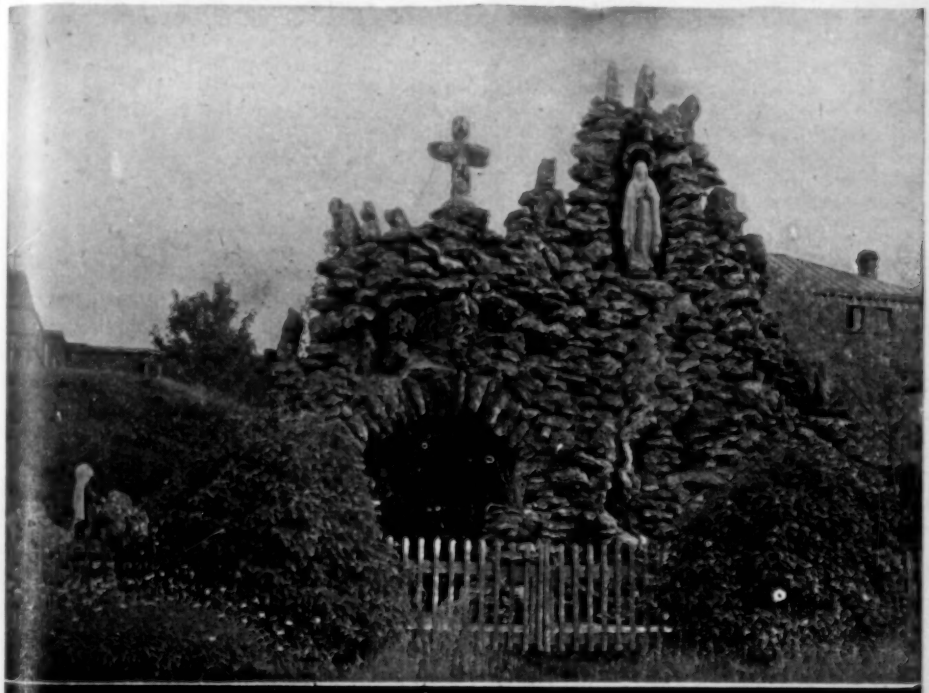
Pennsylvania Germans settled in what is now Albert County. Their family names are woven into the history of the province which they made their own in the latter part of the eighteenth century. Their thrift and industry have helped to build New Brunswick, as it built Pennsylvania into a great state. The German settlement was very small and the family names remarkably few. These few families have multiplied mightily and there are hundreds, even thousands, of people with the same family names all along the banks of the Petitcodiac.

Perhaps it tells something also about New Brunswick to state that it is the province least influenced by the drive and enterprise of the Scot. A vivid contrast to Nova Scotia and Prince Edward Island! The relatively few Scots have given a good account of themselves, as they always do—particularly in business; but there has never been a Scottish interest as elsewhere in Canada. At the pre-

sent time, Premier John B. McNair and Opposition Leader, Hugh Mackay, both happen to be Scots, but it has taken one hundred and sixty years for this remarkable coincidence to occur; some indication of the formidable obstacles which have faced Caledonian enterprise in the province.

The province could well cry in a loud voice, "God Bless the Irish!" for without them provincial life would have been dull and formal indeed. Before their arrival in the 1840's, New Brunswick life threatened to degenerate into colonial rigidity. After the Irish arrived in force, there was never any possibility but that provincial life—and particularly politics—would be colorful and interesting from then on. Irishmen have always taken a disproportionate share and interest in politics and, professionally, in the legal profession. Some of the greatest orators have been Irishmen and they have always been the wits of provincial society.

The history of the Acadian race is one of the most romantic and tragic in America. Until a few generations ago it seemed as if limitation and frustration would encompass their destiny forever. The Acadians must not be confused with the French-Canadians. They are a unique people. Most French-Canadians are of Norman descent while most French-Acadians are of Breton descent. Acadians are now one-third of the population of New Brunswick. Each year there are more Acadian children born than all others combined. The few tragic and ruined families who hid their misery in the forests of eastern New Brunswick after the



One of New Brunswick Picturesque Grottos

Expulsion (1755) have increased to over 150,000 people, with a prosperous economy, noble churches—a great cathedral in Moncton, its tall spire, a symbol of racial pride and resolution.

Cultural and racial factors are important but economic circumstances also play their part in determining the provincial pattern. There is a rather violent paradox in New Brunswick life between the formal character of its institutions and the haphazard play of economic forces. One can know little about the province without realizing the importance of *The Forest.*

Few provincial communities are out of sight of The Forest and, indeed, the settled places are at best modest encroachments upon the great domain, a large part of which is still in title to the Crown. If men falter for a few years in ploughing their fields, the trees march back like a conquering host. Always there has been this struggle with The Forest—for wealth—for mere existence—for very life. It has absorbed the strength and energy of generation after generation. In the background, then, behind the formal façade of provincial institutions, there has always been this arduous, uncertain, and generally undisciplined life of the lumber-camp and river-raft. This has existed from the very beginning. The Loyalist settler, lawyer or royal official though he might be, had to go into the woods. He had to bed down in skins, live in a shack, travel on a raft, drink rum instead of port. The clergy always fulminated against the intemperance of the camps but scold as they might The Forest imposed its peculiar rites upon its initiates. So it was that what *The Sea* became to Nova Scotia, The Forest became to New Brunswick, at once a refuge, a field of opportunity and (sometimes) a prison.

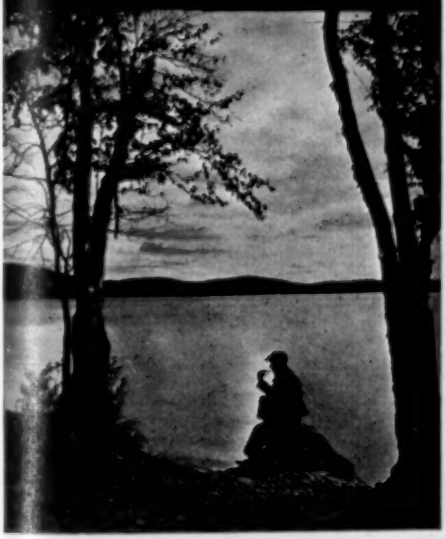
The timber trade began in the 1770's with a brisk business in shipmasts for the Royal Navy. It grew into an industry when Napoleon's Berlin Decree shut off Baltic timber from British markets. It reached its peak in its first century in the Golden Age of ship-building, i.e., 1830-70 when most New Brunswick harbors were home-ports of whole fleets of sailing vessels. There was a slow, gradual decline in the long-lumber business from 1870 until 1920. In 1921 the sudden and disastrous collapse of post-war lumber prices almost ruined the province. During the past twenty years, the pulp and paper mills in northern New Brunswick have proved substitutes for a long-lumber industry which has never recovered from the catastrophe of the early 1920's. During World War II, a new hard-wood industry has grown into real importance and a number of secondary industries, based upon wood fibre, offer considerable means of overcoming some of the weaknesses inherent in lumbering as a primary industry. Today, the forest income of the province is nearly one hundred million dollars annually, dwarfing every other form of enterprise as always, and engaging the energies of by far the greatest part of the population.

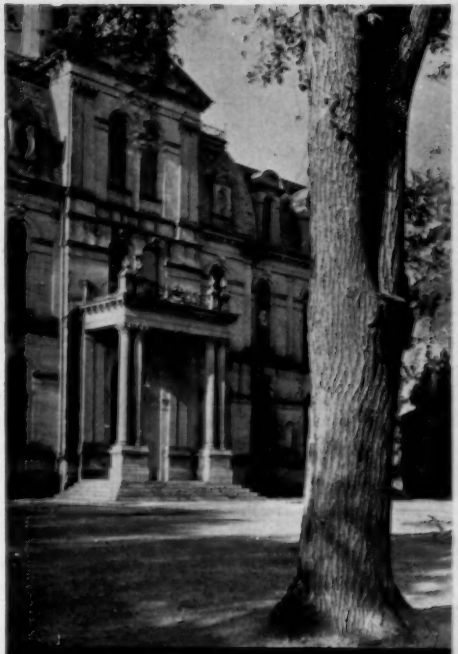
The commonest complaint of economic experts in regard to the New Brunswick farmer is that he is inclined to be too versatile. The twelve-month year is scarcely long enough to give him time for all his activities as farmer, fisherman, lumber-jack, and railroadman. Perhaps too many provincial farms are of the marginal-subsistence variety but, for all of that, New Brunswick potatoes, from the Upper Saint John Valley, and New Brunswick apples, from the Lower Valley, enjoy a wide circle of fame. The pastoral sections in the older districts are situated along the river valleys. They have an orderly charm like New England or Old Ontario in contrast to the frontier settlements in the North where shacks and clearances look like something out of Kreighoff or Paul Kane.

The province is both old and new. The first hearth was alight before Shakespeare had written "Macbeth." This was in 1604, and when Demont's little company gathered around those flames on an island in the St. Croix River, they were the only white faces

Satisfaction

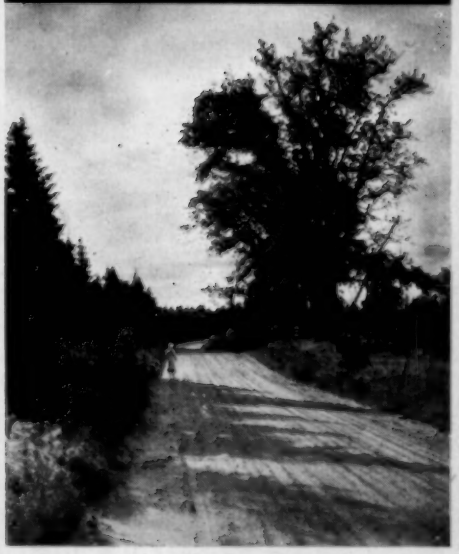
A beautiful scene at Skiff Lake





Picturesque Parliament Building, Fredericton

Off the Beaten Path

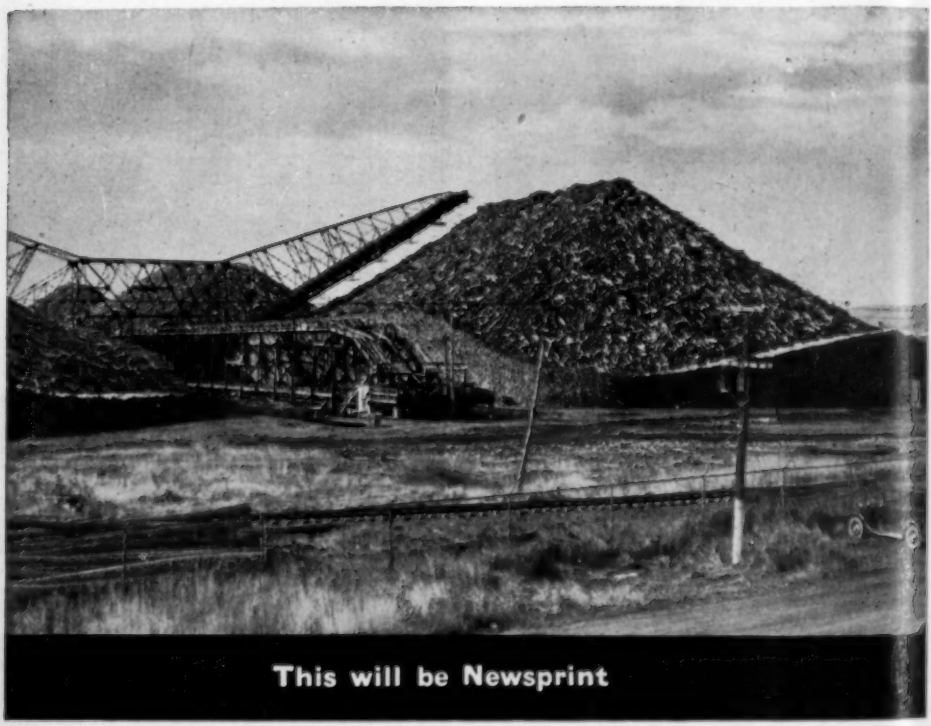


All photos used in this article courtesy of New Brunswick Gov't. Bureau of Information & Tourist Travel.

between there and Florida. The Puritans were sixteen years away from Plymouth Rock. Cabot and Cartier probably saw the low, fogless shores of eastern New Brunswick. Nicholas Denys carried on a fishery on the Miramichi and had a good business when Marlborough was a boy. That bustling promoter, Charles LaTour, was carrying on ambitious projects along the Bay of Fundy shore before the Hudson's Bay Company was established. Rocky pastures, a few miles below Fredericton, were cleared in the year that George III came to the throne. Around Sackville you can trace the firing-lines of the most saguinary of the colonial wars at Fort Beausejour.

Yes, the province is old but it is a young province, too. The birth-rate in several recent years has been higher than that of Quebec. In some parts of northern New Brunswick it is higher than at any place in the Western World. The new pulp and paper towns bustle in the shadow of the towering mill-stacks, to the throbbing pulse of great machinery. In Saint John harbor the flags of all the maritime nations come and go. The airport at Moncton receives great planes winging from the ends of the earth. A remarkable system of paved roads, which has cost almost eighty million dollars since 1925, traverses the province. Per capita, New Brunswickers have spent more on their roads than the citizens of any other province.

While the economic production of the province is important, New Brunswick is far more famous for its nurture of exceptional human beings. No other province has produced so many great, near-great, and generally competent individuals in proportion to its population. A Prime Minister of Great Britain; a Prime Minister of Canada; statesmen like the Rt. Hon.



Lord Beaverbrook, who whimsically took his title from a flag-stop on the C.N.R.; educationalists innumerable; millionaires; poets—Roberts and Carman; bishops, archbishops, and missionaries; generals. The professional groups are filled with New Brunswickers from coast to coast. Top-flight banking has at times looked like a provincial prerogative. The ambitious young person born in New Brunswick can count the very fact as an invaluable heritage. Never challenge any moderately well-informed native of the province to name the Honor Roll. He can go on for hours.

It has tradition. It, alas, has a rigid economy. For many reasons, it produces exceptional people. Finally, New Brunswick is beautiful in the scenic sense. The landscapes are not dramatic. They do not dwarf and overwhelm men but surround them. It was meant to be lived in.

The Forest itself is not the mass-production forcing-ground for jack-pine but a place of variety and beauty. Some of the white-pine remains. Spruce is the principal growth but most other commercial soft-woods exist in quantity. There is much hard-wood; not merely the mediocre grey birch but white and yellow birch, beech and the maples. Elms line the river banks as a kind of liaison between forest and settlement. The color of the landscape is always changing—from dawn to dusk—from season to season. The New Brunswick autumn is a time of unrecordable beauty; no paint or photographic film will ever get down more than a rough approximation of it. This miraculous technicolor is, unfortunately, turned on after the regular tourist season is over.

Few New Brunswickers are out of sight and sound of water. There are thousands of streams of every size from the great Saint John and Miramichi Rivers to little trout streams bubbling from a spring. The centre

A fresh catch of lobsters

of the province is a vast network of lakes, brooks, and rivers, with the headwaters of the Restigouche, Nepisiquit, Miramichi, and Saint John only a few miles apart.

There are two sea-coasts very different from each other. The Bay of Fundy forelands are of rugged limestone which descend starkly into rushing tides and deep water coves. The northern and eastern shores on the Gulf of St. Lawrence and Northumberland Strait are low, with sandbars and islands. The fisheries are all in-shore. There is no deep-sea fishing fleet as there is in Nova Scotia. The fisheries are highly specialized. The greatest sardine fishery in North America is centred on the Charlotte County shore of the Bay of Fundy. Lobsters are processed and also shipped alive in great quantities. Smelt and oysters are supplied to half a continent.

The Restigouche River is one of the great salmon streams of the world. Famous sportsmen for generations have prized a Restigouche salmon above most sporting spoils and the banks of the river are leased at rentals.

New Brunswick place names are lovely and fantastic. Restigouche, Nepisiquit, Miramichi, Kouchibouguac, Kouchibouguasis, Richibucto, Buctouche, Shediac, Petitcodiac, Washademoak — are Micmac and Malicete Indian. British statesmen enjoyed a great vogue during the nineteenth century—Gladstone, Palmerston, Lansdowne, Dufferin, Beaconsfield, Manners-Sutton. Then there is the rosary of the names of the Saints in the Acadian districts, while, of course, Georges, Alberts, Edwards, Victorias, Royals, Kings, Queens and Princes, innumerable, are most befitting to such a loyal, old province.

Very competently prepared tourist literature will instruct the visitor where to go in the province. There are many historic sites set amidst the superb scenery. The superficial picture of New Brunswick is very attractive. The tourist industry is extensive now and obviously destined to become more important year by year. The visitor who wishes no more than scenery, sports, and sea-bathing will go home more than satisfied, but for those who wish to delve deeper into the history and tradition of a dignified but hospitable provincial household, there will be a welcome and great treasure.

R *Chuckles* P.R.N.

Animal inoculation is the direct entrance of the disease organism through being bitten by the animal having the disease.

Umbilical hernia is where the umbilicus gets weak and passes out.

A colon irrigation is given (1) to aid in inflammation and relieve it, (2) for protusion of the bowel, (3) to start paralysis.

In diphtheria, all contacts should be burned.

The artery to the uterus is the spermatic.

During the delivery keep the husband happy. Let him read a book with a happy ending.

Increase humidity in the sick room by shaking a damp sheet around.

In colic, the baby is in distress or it soon will be.

Give a sedative when the patient loses her sense of humor.

As preparation for breast feeding some obstetricians advocate beer and peanuts.

The thermal death point, which is the number of units required to produce toxemia in a rat, is the highest temperature reached just before the patient dies.

Prevention of Dermatomycosis

Prevention of tinea infection is chiefly a matter of personal hygiene. The feet should be washed thoroughly twice a day with soap and warm water and the toes carefully dried. Powder should be applied freely after bathing and in the morning, especially between toes, to the groin and navel. The type of powder is not as important as the habit of using it freely and regularly; ordinary borated talcum does very well. An astringent such as rubbing alcohol may be helpful. Socks should be changed daily, or twice daily when feet perspire excessively. Cotton socks are best in hot climates, and the wearing of perforated shoes and open sandals is recommended.

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

A New Approach to an Old Problem

M. CHRISTINE LIVINGSTON

THE WORD "chronic" as applied to a patient has, until recently carried with it various connotations, probably the chief one being "incurable." Fortunately, today this term is being replaced by the expression "long term illness" which bears a more hopeful implication. Coincident with the use of the new term there has been an increased emphasis, more positive in approach, toward the care of patients in this group. Much has been written on the subject of the earlier rehabilitation of patients in every type of illness which need not be repeated here. The purpose of this article is rather to relate the attempts of the Victorian Order of Nurses, Greater Montreal Branch, to learn the most modern methods of nursing skills to better meet the needs of patients suffering with long term illnesses. A staff education project was undertaken through which the Joint Orthopedic Nursing Advisory Service (JONAS) of the National Organization for Public Health Nursing provided lectures and demonstrations to the entire staff of fifty-five nurses. Miss Louise M. Suchomel, consultant in Orthopedic Nursing of JONAS, conducted the conferences which were held over a period of ten days. In addition to staff conferences, Miss Suchomel visited community services to study available facilities contributing to the physical restoration of convalescent patients, and to make suggestions regarding their use.

It is difficult to fully estimate the value of this staff educational project as each day new results are being obtained. As one step leads to another, continuing opportunities are presented for further action, and there is a new, enthusiastic approach in applying modern nursing skills. One nurse in remarking on her own reaction said, "Now it's not 'Just *another* chronic,' but instead 'What a *wonderful* chronic!' "

The program was undertaken as the result of long-felt concern by the staff

Correct alignment in sitting positions: Note adjustment to floor and chair.

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about the increasing calls for service to patients with long term illnesses and the responsibility of the Victorian Order toward this major community problem. It was recognized that a large proportion of our patients were suffering from hemaplegia, heart conditions, arthritis, rheumatism, and cancer. It was also recognized that, with the continuing shortage of hospital beds as well as the lack of adequate institutional care, the number of such patients requiring service would inevitably continue to increase. The hopelessness of the patients' condition, combined with the reluctance or inability of the family to give care, challenged Victorian Order nurses, as they worked in homes, to find some solution to this problem. Therefore it was agreed that the Victorian Order, as one of the chief community facilities providing convalescent care, should be prepared not only to accept this responsibility, but to provide, as in every other type of illness, the highest standard of skilled nursing care. From the very beginning of the program each staff nurse took an active part and their participation is responsible to a large degree for the success of the undertaking. After certain necessary organization details were cleared a committee of twelve members was formed. Nurses elected by the staff of the five district offices, the supervisory nurses, together with the educational director and superintendent of the branch composed the personnel of the committee. The suggested outline for institutes prepared by JONAS was followed and this group became the Planning Committee. Three meetings were held to plan the program and one to evaluate it in terms of practical application with suggested methods of follow-up. In addition, committee members held meetings in their district offices to keep the entire staff up-to-date with developments. The purpose of the Planning Committee was to select topics for discussion, to decide on means of covering the service during the conferences, and to appoint subcommittees.

In selecting topics for the conferences it was agreed that there were many areas of nursing care in which help was needed, but preference should be given to existing problem conditions. This was necessary as lectures and demonstrations to be given by JONAS to the Victorian Order staff were of necessity limited in time and number. The committee members, therefore, presented the most pressing needs of patients and nurses based on the experiences of the group they represented. It was soon discovered that the experiences of each group were closely related. A study of the chronic case load of the five districts revealed that patients suffering from hemaplegia represented the largest number receiving care. It was also common experience that many of these patients, partially paralyzed by their disease, were in addition severely crippled in unaffected joints and muscles. Except in rare instances patients and families accepted such conditions as inevitable. Nurses were experiencing frustration and fatigue as nursing care was given, week after week, with little or no progress in the patient's condition. To many staff members, care under such circumstances was a routine job, uninspiring, even monotonous, as it provided little satisfaction or challenge. There was complete agreement among the members of the Planning Committee in defining the problem, which resulted in the following topics being selected for the conferences:

1. Care of patients with long term illnesses, especially those with hemaplegia.
2. Early recognition of crippling conditions in every type of illness, especially those of long duration.
3. The prevention of fatigue through correct posture of the nurses.

The information regarding the selection of topics was forwarded to JONAS, following which reference reading material in reprints and handbooks was provided for each nurse.

The reading guides were supplied by JONAS free of charge in advance of the conferences. The members of the committee distributed them to each nurse and stimulated discussion and study of the material among their

Demonstrating correct position for left hemiplegia. Use of weighted box, rolled bath towel, and pillow for support in a back-lying position.

separate groups. They were used during the conferences as references and have remained in the possession of each individual nurse for permanent guides.

Covering the service during the time conferences were held for the entire staff presented some difficulties, but the problem was not insurmountable. The Board of Directors, on the recommendation of the Advisory Nursing Committee, had given unqualified support to the program so that extra relief nurses were employed. Married nurses, normally working on a part-time basis, willingly came on duty full-time as necessary. Case loads were adjusted by the staff well in advance and, with the co-operative effort of all, the work was covered.

The sub-committees were responsible for securing a suitable place in which to hold the lectures and demonstrations, for assembling equipment needed, for appointing chairmen and monitors for each session, and for obtaining models. The teaching unit of the school for nurses of the Montreal General Hospital was generously provided. Foot-boards, pillows, blankets, towels, projector machine, beds, and other necessary equipment were made available for demonstration. The principal of the Montreal High School for Girls selected two young students, interested in becoming nurses, who volunteered as models. One of the models, a bright young girl, seventeen years of age, became so proficient in demonstrating correct posture and was so enthusiastic about her newly acquired knowledge that she provided her own demonstrations later to her classmates at school.

The program, planned by JONAS to meet the problems as defined by the Victorian Order, consisted of five sessions held from 2:30 to 5:00 p.m. Total group conferences were held on two successive days and were attended by fifty-five staff members. The material presented by Miss Suchomel was directed toward the following subjects: Session 1. Posture in Rest and Activity. Session 2. Protective Body Mechanics of the Convalescent Patient and Nurse. These two sessions were lecture periods illustrated by

slides and anatomical charts. The third session was repeated three times and was attended by smaller groups of eighteen nurses. The subject of this session was: Functional Anatomy and Bed Positions for Specific Patients. A lecture with demonstration was followed by practice periods in which everyone participated.

It is not possible to include here the full content of the lectures given or to describe the demonstrations and practice periods but, as a result of them, Victorian Order nurses in Montreal have acquired, not only new skills but a new attitude in giving nursing care to every patient served. Modern skills in all nursing care incorporates a better understanding of anatomy, posture, and body mechanics. At the end of the first lecture period an experienced, skilful nurse remarked, "Why didn't we have this before?"

On the conclusion of the lectures and demonstrations the post-conference meeting of the Planning Committee was held. After a review of the objectives of the project and a discussion of the program as presented, the following recommendations were drawn up:

1. That a review be made of community facilities so that: (a) A plan be considered for staff members to visit local hospitals and clinics. (b) An effort be made to improve referral programs.

2. That an article be prepared for *The Canadian Nurse* on the staff educational program.

3. That the McGill School for Graduate Nurses sponsor an institute on Body Mechanics early in 1948.

4. That the assistant director, McGill School of Physical Therapy, be invited to participate in the Victorian Order staff educational program.

5. That a study be made of each nurse's case load to learn of patients who might benefit by physiotherapy and/or consultation with a physiotherapist.

6. That the Planning Committee be retained as the Orthopedic Committee to maintain interest and to motivate nurses to apply the principles of posture and body mechanics in their daily activities and in patient care.

7. That conferences be planned for further discussion and practice periods in district offices.

8. That the committee meet in two months' time for the presentation of case studies showing the application of principles of body mechanics.

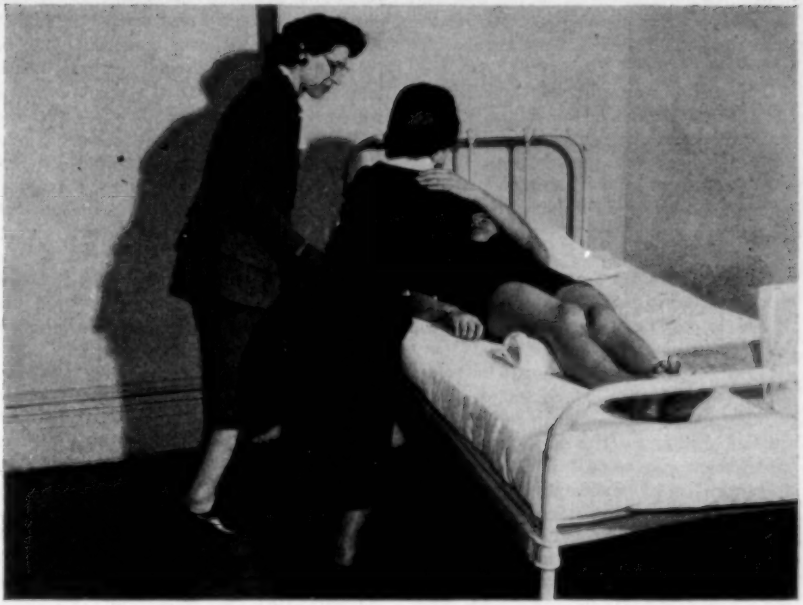
Four months have passed since the program was undertaken. Because of the continuing enthusiasm of the staff as a result of the practical benefits received, the recommendations are being carried out. Many other positive and satisfactory results have been obtained. It is not unlikely that the most important result of the whole program has been the renewed faith of the Victorian Order nurses in the art and science of modern nursing skills, with an increased understanding of the important part it plays in the recovery of all patients.

Case Histories

The three case histories, prepared by Mrs. Beatrice Wolfson, will serve to illustrate, in some measure at least, the value of the conferences:

Case 1. Mr. G, an artist, aged 53 years, suffered a stroke and was immediately referred by the family physician to the Victorian Order for general nursing care. The diagnosis was left hemaplegia and hypertension. The patient's wife and mother had both died within the past year and he had also lost a son in the war. At the time Mr. G became ill, the household in addition to the patient consisted of a twenty-year-old daughter and a seven-year-old son. Since the daughter was the sole support of the family she was away from home all day. The responsibility for the care of the father between the nurse's visits was at first assumed by the little boy. A kindly neighbor was found who soon took over the household duties and the lad returned to school.

On her first visit the nurse found the patient with a moderately severe paralysis of the left side and some incoherency of speech. His left arm was contracted across the chest with all the muscles stiff. The doctor was consulted in regard to the amount of physical activity permitted the patient before instruction was given to the family. The son and the neighbor were taught how to place the pillows correctly and to change the patient's position at periodic intervals. A



Demonstrating use of good body mechanics to avoid undue fatigue and strain in raising patient to sitting position.

folded cloth was placed in his left hand to allay contraction. A sling was tied to the head of the bed to support the arm during periodic extension of the muscles. As the nurse placed the patient's left foot in the basin during his bath he was encouraged to increase movement of his knee and hip joints. Gradually contractions lessened and at the end of seven weeks his left arm was almost at full extension and Mr. G was able to dress himself. After two months he was dismissed from nursing care, when the doctor made arrangements for him to receive physiotherapy treatments.

In this particular case, early and continuous care, together with the resolute determination of the patient and his family, helped to prevent crippling deformities and enabled Mr. G to make a satisfactory recovery.

Case 2. Mrs. C was 67 years of age when she developed arthritis. Gradually during the last two years her condition had become progressively worse until she was completely confined to her bed. During this time the family called the Victorian Order at intervals when routine general care was given. The patient's knees were swollen and contracted and her arm and hand movements limited. She was barely able to feed herself. To Mrs. C and her husband, and probably to the nurse at this time, there seemed no alternative to chronic invalidism.

Following the lectures and demonstrations, the nurse giving care to Mrs. C consulted the doctor regarding the amount of physical activity that could be undertaken by the patient. Exercising the hands and fingers through opening and closing the fists was per-

Demonstrating good body mechanics for patient in sitting position.

mitted. Gradual extension of the arm and leg muscles was undertaken and Mrs. C was encouraged to comb her hair to give shoulder movement.

The patient was extremely apprehensive but the nurse's confidence gradually overcame her fears. After weeks of encouragement in moving her arms and legs, Mrs. C was convinced of the value of exercise. Both husband and wife worked diligently between the nurse's visits on the activities prescribed. In two months, Mrs. C was able to be up in a chair and one month later was walking a short distance with assistance.

The scepticism of the patient and her family regarding the possibility of any physical restoration constituted the chief problem in this case. There will doubtless be little more progress due to the patient's age and infirmities. However, the present improvement has enabled her to be more independent and more content.

Case 3. Mr. X, a widower, aged 47, was referred to the Victorian Order of Nurses by the Social Service Department of a hospital. He had suffered several years with rheumatoid arthritis and was returning home after three months in hospital, showing little improvement.

Arriving in the home the nurse found the patient depressed and apprehensive. He was unable to feed himself or light a cigarette. His knees were contracted at an angle of 45° and he could not sit or stand.

Mr. X has two sons. One is 22 and operates the grocery store by which the family is supported. The other son is 21 and is in second year university. His fees are covered by scholarships and bursaries. Both boys were home on the nurse's first visit. After giving the necessary care the nurse instructed the sons regarding a foot-board to prevent bed-clothing from hampering foot movement, and a board to place under the mattress to enable the patient to keep better body alignment. Instructions for exercises were obtained from the physician. The sons were taught the exercises and supervised them at night. The nurse made daily visits for six weeks to give nursing care and to supervise the exercises in the morning.

Over a period of two months the patient's condition gradually improved. He gained weight, was able to feed and shave himself and to light his own cigarettes. Nursing visits were spaced at longer intervals as this improvement occurred. The contracture in the knees has lessened and they can be lowered about one and one-half inches. Pain has disappeared. The latest x-ray reports show an ankylosis of the joints so it cannot be expected that complete recovery will take place. Mr. X was referred for occupational therapy treatments. It is hoped that by encouraging him in this and in other fields, as well as by maintaining the improvement in his physical condition, he will be better able to adjust to a life necessarily restricted in activity.

Further plans to improve service to the chronically ill patient will include wider use of community resources. The most important aspect of the lectures and demonstrations given by JONAS has been the change in the attitude of the Victorian Order nurse herself and the reflection of her hope and belief in the attitude of the patient and the patient's family towards long term illness.

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Loyalty

Contrary to the opinions of many people, loyalty is generated at the top and flows downward. The leader gains his loyalty only on the rebound, somewhat as the reflection of the radar wave which is sent out into space, strikes something, is reflected back, and appears upon the screen at the point of origin.

— MAJ. GEN. PAUL R. HAWLEY

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

The Clinical Program

ELLA M. HOWARD

THE OBJECTIVES in giving instruction and experience in medical and surgical nursing will be influenced by the philosophy of the school of nursing and the objectives of its educational program. They would include such factors as knowledge, skill, attitudes, cure and prevention, social and health aspects and rehabilitation as applied to the care of medical and surgical patients. It is essential that objectives be set up as a guide to instructors and students.

The educational program should have as its ultimate objective the rendering of *good* nursing service, both curative and preventive. If nursing students are to develop the ability and desire to give *good* nursing care, they must observe and practise nursing as *students* in fields where patients are considered persons, members of families and a community, and are receiving good nursing care. This latter must be kept in mind when considering clinical experience.

PLANNING CLINICAL EXPERIENCE

Planning the student's experience in medical or surgical nursing may be considered under several headings:

Who does the planning? It is essential that those who are to guide the student's education in the clinical field as well as the classroom should have a part in planning her program. Therefore, the director of nursing education, who really acts as educational co-ordinator, instructors, both classroom and clinical, and the head nurses concerned should take part. Each has her own particular contribution to make and each must understand her place in the over-all program.

Survey of resources: Only through a careful analysis of the educational resources of the clinical services and units of those services can a constructive plan be made for the student's clinical experience. Though quantity in regard to patient census is not always a criterion, there must be variety and adequate experience available. The best learning experiences should be selected and students should obtain essential experience.

Equipment and facilities necessary for patient care must be available. In addition there should be a ward classroom on or adjacent to the unit. It should be equipped with blackboard, bulletin board, ward library, chairs, and so on, for the use of students and instructors.

Personnel: All personnel should know their places in the students' program and be aware of the position of students as *students*. The clinical instructor should be well informed in medical and surgical nursing. The head nurse plays a valuable part not only in teaching students but in her

Miss Howard is on the faculty of the School of Nursing of the University of Toronto.

attitude and the atmosphere of the ward. The general staff nurse must not be forgotten, for she plays an important part in demonstrating good nursing care. There should be adequate graduate staff to ensure good nursing care, and to make the clinical program possible.

Placement: Medical or surgical nursing will be the first clinical experience following the preliminary term. Care on the medical wards is considered basic, but with a large class it might be necessary to divide the group, sending half to each experience.

Considering surgical nursing, as an example, a number of questions must be answered. What is the length of the first experience? What is the first experience to include? During the first assignment, are we considering the pre-operative or the post-operative nursing care of fairly convalescent patients, or is the student giving the complete care pre-operatively and post-operatively to her patient? If the latter is the plan, then what divisions of surgical nursing may be included? Are we planning for some surgical nursing experience during each year of the student's education? Are we considering junior and senior experience? When would experience in orthopedics, eye, ear, nose and throat, neurosurgery or chest surgery be advisable? Each school must decide for itself the plan that is best for its students because all schools have not the same services and few have everything. The *Proposed Curriculum for Schools of Nursing in Canada*, the *Supplement*, and the registration requirements for the province act as guides for planning definite hours of instruction and days of experience.

Neither the placement of the experience nor the arrangement of divisions causes undue concern providing the *whole* experience is *planned* with attention to progressive difficulty and responsibility and there is *adequate instruction on the ward.*

Assignment of students: The assignment of nursing students for medical or surgical experience should be made by the director of nursing education. Only in this way will the experience fit into the total curriculum of the student at the desired time as planned in the over-all program. A definite number of students should be assigned to medical or surgical nursing experience at the same time and for a definite period of time. In most schools of nursing it is the practice to consider such procedure essential in the operating-room, obstetrics, or affiliations, yet the same consideration is not given to the medical or surgical departments. When students having similar backgrounds of experience are assigned together it facilitates group teaching.

In well organized medical or surgical departments consisting of several wards or units with segregated services, the group of students may be assigned to the department. There the supervisor with her clinical instructors and head nurses plans the rotation through the department and the accompanying program of theory to make the experience complete. The length of time which a student spends in any one clinical service does not guarantee sufficient or effective learning, though here again one should consult the *Proposed Curriculum* and registration requirements.

Program: The complete plan will indicate doctors and classroom nursing lectures as part of the ward experience. Experience must coincide with teaching. This necessitates repeating the lectures to each group. We do not question the possibility of repeating instruction by nurses, but sometimes hesitate to ask doctors to repeat theirs. It is the trend to have a number of surgeons lecture in surgery and, likewise, several physicians to lecture in medicine. Each gives that unit or division which really is his specialty. Therefore they will consist of fewer periods, frequently only two or three hours. These, if repeated two or three times a year, would not add to the total sometimes requested of a busy doctor.

The classes would be small and some instructors feel the doctors would not wish to lecture to eight or ten students. If the doctor is an

instructor at heart he should appreciate the smaller groups. In small schools he is accustomed to it. The classes might be held in the ward classroom or clinic room with patients. This is the type of class the surgeon has with medical students, therefore he will not question the procedure. When the whole program is explained, doctors are most co-operative.

Students should be encouraged to apply their knowledge of nutrition, pharmacology, anatomy, physiology, and bacteriology to the nursing of patients with medical and surgical conditions. Associated services, such as out-patient clinics, community facilities, and agencies, should be utilized.

There should be definite periods for planned ward classes and clinics. The number of these will be governed by the classroom program of the student. If we expect students to prepare material and to contribute to ward classes, then we must consider her lecture load for the week.

Attention should be given to the best time for ward classes for that unit. It must not interfere with the desired experience for the student in the care of her patients. In some schools of nursing visiting hours are utilized. In others that time is considered valuable to the student learning to contact relatives to be more aware of the family and community background of her patients or for the instruction of relatives in the care of the patient about to return home.

Essential clinical teaching must be planned for the whole experience, but it too must be flexible to utilize teaching opportunities and to meet the needs of patients and students. Students having surgical nursing as a second clinical experience (their first being medical) will require a somewhat different program.

Records

Because clinical instruction is becoming more and more important in supplementing classroom instruction, the time spent in this form of teaching should be accounted for as in any other form of instruction. The student should keep her own record. These are valuable as a tool in student guidance and also as a further control and means of stimulating the development of the program as a whole.

Records should be simple, adequate, and not time-consuming. However, certain values are essential:

1. To indicate the previous experience of the student. It is essential to the clinical instructor to plan most satisfactorily for the student and the record should be utilized for conferences with her.
2. To indicate what the particular ward has to offer so the student may know what has been planned and what to expect. It is valuable in the orientation of the student and at the conference when her program is discussed.
3. To help students plan nursing care and nursing care studies.
4. To note progress and achievement.
5. To show experience actually acquired as a basis for the next experience.

Records may vary for different services and are also for different ultimate purposes. Some are merely working records and thus temporary, while others may become part of the student's permanent record. In medical and surgical nursing experience records it is difficult to refrain from long, complicated outlines of every type of disease. The record of experience will be governed by the objectives for that experience.

Clinical Teaching

Teaching at the bedside affords unlimited opportunity. Much of this is incidental, but the tendency is to have more planned instruction at the bedside, preceded and followed by conferences to make certain the teaching is effective. General nursing care, treatments, medications, and many observations are more effective if demonstrated at the bedside.

The morning circle following the morning report or such a discussion following afternoon or evening reports may be valuable. It should be brief, definite, and may grow out of the report. One may wish to demonstrate a change of procedure to the whole staff which is thus available. A ward

problem may require the attention of all or a definite topic such as "fluid balance" may be discussed.

Nursing clinics are more time-consuming and held less frequently. The patient is present part or all of the time. All ward teaching should be related to patients receiving nursing care. Students taking part in the clinic must be given time for preparation. Time should be allotted to those taking part in the clinic, as doctors, students, social workers, and so on, to select material most pertinent. Nursing clinics should not be held only on the *unusual* patients.

Ward classes may include any or all types of teaching on the ward. They may be planned periods of 20-30 minutes and held in the ward classrooms. A discussion of specific phases of nursing care is related to patients on the unit. The information previously acquired from doctors' and nursing lectures is being applied to the nursing care of a specific patient who has a specific disease condition. Conferences, both individual and group, are most valuable. Individual conferences should be conducted when the student arrives on the medical or surgical service, the purpose being to discuss her plan of experience, to examine previous records, to discuss the student's difficulties and for orientation to the unit and to her assignment. They should be held whenever desired by the student or the instructor and at the conclusion of the student's experience. The last conference is arranged to examine records and reports obtained and experience gained.

Group conferences are used frequently as a method of conducting ward classes. Students thus take an active part in the discussion and frequently lead the conference.

Rounds, both nursing and medical, may present valuable opportunity for learning. Care should be exercised to make them purposeful. Students should know what to observe and a conference following will check the results of the observations. The purpose might be to observe two patients with different conditions but both cyanotic, to observe special nursing techniques, or to note various appliances for similar fractures. A student might be instructed to be at the bedside of one of her patients during doctors' rounds to learn from the discussion of the medical staff.

Nursing care plans and nursing studies when used as tools for learning are valuable. Students should be encouraged to plan nursing care.

Suggestions

In an attempt to have students consider the *whole* patient as a person and to see the complete picture, the following suggestions are offered:

The out-patient clinics may be attended at the time of the ward experience in that field. The student might, for example, accompany her patient to the chest clinic or eye clinic and remain with him during his examination and instruction.

The student may accompany a patient to x-ray to observe a fracture and application of cast. She would then give nursing care to that patient on the ward.

A student might admit a patient, give the pre-operative care, accompany him to the operating-room to observe the surgery, and then give the post-operative nursing care.

A diabetic patient might be accompanied to the diet kitchen and laboratory where he is to receive instruction.

If a patient for gastro-intestinal series is accompanied to the x-ray to observe the fluoroscopy, it will emphasize the need for careful preparation.

Definite use should be made of community resources to further emphasize the fact that the hospital is one of the community's health agencies.

The above are only a few of the learning situations one might suggest. These should be preceded and followed by a conference to be certain of their value. It might not be possible, in fact not necessary, for every student to attend all. Each would attend some and report to the group at a group conference.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

La Paraldéhyde

G. GINGRAS, M.D.

Notre page, ce mois-ci, est consacrée à l'enseignement de la pharmacologie. Monsieur G. Gingras, M.D., officer médical en charge du centre des paraplégiques de l'Hôpital des Vétérans à Ste. Anne de Bellevue, P.Q., nous parle de l'emploi d'un bon vieux médicament, un classique de la thérapeutique — la paraldéhyde.

Puis cet article est suivi d'une petite étude sur les buts des cours de pharmacologie et quand doit-on donner ce cours — 1ère année? 2e année?

En usage depuis 1882, la paraldéhyde est encore considérée de nos jours comme un puissant hypnotique, quoique son usage soit de moins en moins fréquent et qu'on lui substitue des produits plus à la mode.

La paraldéhyde est un polymère de l'acétaldéhyde, à odeur forte et caractéristique au goût désagréable, ce qui explique probablement son usage de plus en plus restreint.

Son action sur le système nerveux central est très rapide. De 10 à 15 minutes après ingestion de 8 à 10 cc. apparaît un sommeil normal, rarement précédé d'une phase d'excitation et qui ne procure pas au malade un réveil difficile et la période abattement que procurent de nombreux hypnotiques.

Quelque soit la dose employée la paraldéhyde n'a aucune action analgésiante mais provoquera souvent le sommeil malgré la douleur. L'absorption du médicament est extrêmement rapide; en moins de quelques minutes après administration, son odeur peut être reconnue dans l'haleine.

La toxicité de la paraldéhyde est basse. Les tentatives de suicide réussissent rarement et d'énormes doses données par erreur, l'une d'elles allant jusqu'à 104 cc., n'eut de conséquence qu'un état d'inconscience prolongé.

La dose normale est de 3 à 15 cc. La difficulté cependant est de faire accepter une médication dont l'odeur et le goût sont désagréables. On a conseillé, comme véhicule, le lait, le vin, les jus de fruits.

L'administration par voie rectale est aussi recommandée. Habituellement, 10 à 20 cc. de paraldéhyde sont mêlés à parties égales avec de l'huile d'olive ou de paraffine, le mélange causant le minimum d'irritation à la muqueuse rectale.

La paraldéhyde est prescrite avec des résultats satisfaisants dans l'alcoolisme aigu, les cas d'empoisonnement par la strychnine ou la cocaine et autres. Cependant, chez les grands agités son administration *per os* ou par voie rectale demeure quasi impossible et le but principal de cet article est de démontrer que dans certains cas où il est nécessaire d'agir rapidement, son administration intramusculaire est plus sûre, moins compliquée, et plus efficace. Au cours de la dernière guerre plusieurs milliers de cas de traumatismes craniens en état d'extrême agitation ont été traités au moyen d'injections intramusculaires de paraldéhyde, la dose variant de 5 à 10 cc. Les résultats ont été plus que satisfaisants, la paraldéhyde n'ayant comme les opia-

cés la faculté d'abolir certains signes neurologiques importants.

Par ailleurs, on a réussi à enrayer plusieurs cas de status épilepticus au moyen d'injection intramusculaire de paraldéhyde là ou les médications usuelles s'étaient révélées inefficaces.

La paraldéhyde, en injection intraveineuse, n'est pas sans risques. Cette voie d'administration a été la cause d'oedème aigu pulmonaire et de collapse respiratoire.

Enfin rappelons que le combination morphine-paraldéhyde est très toxique et que ces deux médications ne devraient jamais être prescrites conjointement.

L'Enseignement de la Pharmacologie

Tout le monde semble d'accord dans nos écoles d'infirmières sur les buts du cours de pharmacologie, à savoir:

1. Donner des connaissances théoriques en enseignant à l'élève: (a) les principes de pharmacologie; (b) l'usage en thérapeutique de produits pharmaceutiques et autres agents; (c) connaissance des médicaments en usage, dosage, méthode d'administration, effet, etc.

2. Donner de la pratique en enseignant à l'élève: (a) les méthodes d'administration; (b) en développant des habitudes de précision et d'exactitude; (c) en développant son esprit d'observation.

3. Développe le sens de la responsabilité: (a) par l'enseignement déjà donné (1 et 2); (b) et par l'enseignement des dangers et conséquences de l'emploi de médicaments sans l'ordonnance du médecin; (c) danger dans l'emploi de narcotiques; (d) connaissance de la législation.

Mais quand doit-on enseigner la pharmacologie à nos élèves? Pour ce qui concerne, les solutions désinfectantes et antiseptiques, la pratique des mesures et la préparation des solutions, le même avis est partagé par toutes — durant les premiers mois du cours.

Pour ce qui est de la connaissance des divers produits pharmaceutiques, de leur emploi en thérapeutique, les opinions sont divergentes. Pour qu'il y ait corrélation entre l'enseignement de la pathologie et de la thérapeutique, quelques-unes de nos institutrices opinent que l'on doit attendre en 2e année. Cela semble assez logique, d'une part d'attendre à la 2e année du cours pour donner cet enseignement, si d'autre part, l'on attend également en 2e année avant de permettre aux élèves de donner des médicaments.

Comment une élève peut-elle donner de bons soins à un malade, si elle ne sait pas pourquoi elle donne tel médicament et l'effet qu'il doit produire? Il semble plus logique et plus juste, pour le patient et pour l'élève, de donner dès la première année des connaissances élémentaires en pathologie et en pharmacologie: par exemple, pourquoi ne pas faire suivre l'étude des différents systèmes en physiologie, de quelques leçons sur la pathologie du même système et sur la thérapeutique employée dans le traitement de ces maladies.

Pour les institutrices, qui désirent rester fidèles aux traditions et ne voudraient changer en rien leur programme, un enseignement clinique intensif en pharmacologie, comprenant l'enseignement de la théorie et la surveillance de la pratique sur place, semble le seul remède. Un programme bien détaillé de l'enseignement à donner à l'élève, en corrélation de l'enseignement qu'elle reçoit déjà en physiologie et en pathologie, devrait être préparé.

Les cas assignés à l'élève devront l'être, en raison des connaissances qu'elle a déjà acquises, afin qu'elle puisse appliquer son savoir et en faire bénéficier son malade. Quelque soit la division du programme d'étude, l'enseignement clinique en pharmacologie paraît indispensable. L'élève devra réfléchir sur l'enseignement clinique reçu, faire des observations, faire le lien ou l'application des connaissances qu'elle a acquises au malade dont elle prend soin.

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Notes from National Office

Biennial Convention, 1948

As these *Notes* are being written, June 28-July 1, 1948, seems far away; time marches on, however, and before we know it the biennial convention will be underway. Registration for the workshops closes *May 15*. To facilitate planning, applicants should register as early as possible. Application forms may be secured from the executive secretary of your provincial Registered Nurses' Association. Registration in each workshop must be limited to fifty. Applicants will be registered in the order in which they apply. To avoid disappointment, applicants are requested to indicate first, second, and third choice.

The workshop is nurse-centred and it is practical. Emphasis is placed on assisting nurses to locate and solve their own problems. Specialists will be available for consultation.

The following are tentative topics for the various workshops:

Public Relations

1. What are the principles underlying a good public relations program? How will you locate community and hospital needs? What methods can you use to interpret hospital services, facilities, policies, etc., to the community? How will you interpret community needs to the hospital? How can you convert moral support into financial support?

2. What relationship does good employee-training bear to good public relations? What groups in the hospital will an effective public relations program involve? How do workers interpret policies to those within and without the hospital? What methods do you employ to help all hospital employees realize their responsibility for interpreting hospital policies?What plan have you for interpreting changes that affect the worker?

3. What contribution has a sound personnel program to make toward more harmonious working relationships within the group and better public relations? How important for good relationships is the recognition that *all workers have feelings?* What are the main causes of employee dissatisfaction? How can merited praise contribute to the well-being of the worker? How does the feeling of being a responsible member of the group react upon the worker? How much thought do you give to capitalizing on the special skills and aptitudes of the workers?

4. What effect has the well-being of the employees upon the hospital's fulfilment of its basic function? What do you consider the basic function of the hospital or any other nursing organization? How do patients interpret hospitals and nursing organizations to the community?

5. What are the major functions for which the public relations executive must assume responsibility in a well-rounded public relations program?

6. Why should the public relations program be presented to entire staff as an integral part of the hospital's service?

Newer Methods of Teaching

What implications for nursing education and practice do you see in the present trend toward regional planning for community health, the hospital taking its place as a vital centre in reorganized community health services?

It has been said that re-examination of the nurses' functions in society calls

for greater emphasis upon the social sciences. Do present curricula in our schools of nursing permit the inclusion of additional organized subject matter? If not, how shall we deal with this demand upon nursing education and nursing practice?

It has been said that the patient-centred approach in the clinical field, together with a deeper understanding of the family and the community, is essential for the nurse in our society. What disciplines and what experiences will best contribute to this end?

What values have the socialized methods of learning for nursing education, and how may these be developed within our present programs?

It has been said that a genuine acceptance of people is indispensable for the professional worker. Our students bring to the school of nursing the attitudes and prejudices which they have acquired as lay people. How can we assist our students in their professional growth toward a more genuine acceptance of patients as people?

It is an accepted premise in nursing education today that all teaching in a school of nursing should centre around the patient *as a whole*. How can we organize our teaching so as to attain this in the following courses: (a) nursing arts; (b) clinical subjects; (c) social sciences.

It is an accepted premise in nursing education today that the nurse should take cognizance of the psychological, social, emotional, spiritual, health, and economic factors in a patient's care. How can we organize the efforts of the various nursing groups so as to promote this broader concept of nursing? What facilities, sources, and methods might be utilized toward implementing this concept? What should be the preparation and function of the faculty in carrying it forward?

Clinical instruction is the very core of the nursing curriculum. How can we place the patient as the centre of clinical instruction? How can we sustain interest in clinical experience in the student's third year? How can we develop professional attitudes? How can we teach the student to work toward professional excellence?

How can we improve our techniques of unit planning in teaching? Selection of objectives; development and use of pre-tests; selection of learning situations; organization of instruction material; selection of activities; evaluation and testing.

It has been said that programs of nursing education should place greater emphasis upon the development of skills in the use of the conference as a method of teaching. What are the values of this method? What are the underlying principles? What are its various forms? What techniques are needed? How does one plan the conference? What is expected of the leader? What preparation is required of the participants? How do we apply its methods to various specific subjects?

Tests and Measurements

Objectives: (1) To learn the principles underlying test construction. (2) To participate in the construction of objective test items in accord with accepted principles. (3) To appreciate the use of test results in educational guidance and evaluation.

Problems for group discussion: Why test? (1) Measurement and its function in the school of nursing program. (2) Principles of test construction.

What to test? (1) What changes do we desire in the learner if instruction has been satisfactory and learning adequate? (2) Characteristics of test devices used in measuring nursing ability.

How to test? (1) The techniques useful to the individual instructor. (2) Rating nursing practice. (3) Appraising the achievement of the student in terms of: (a) understanding, judgment, and appreciation; (b) the social, cultural, and spiritual goals of the school.

Personnel Administration

I. What are the principles underlying good personnel practices and how successful have hospitals and health organizations been in putting

these principles into practice?

II. Have hospitals and other health organizations problems of frequently changing staff? (1) What can administration do to discover the causes of the problem of staff turnover? (2) How do personnel policies affect staff turnover? (3) What is your technique for the initial interview with a prospective employee? (4) What does the prospective employee need to know about the job? (5) Why is it important for the personnel department to interview employees who are leaving the service? (6) What is your procedure for dealing with grievances? (7) How do you handle absenteeism? (8) How does your promotion policy react upon the working force? (9) How do you make policies known to employees? (10) What part do employees play in determining personnel practices? (11) What opportunities are afforded employees for making known their point of view to management? (12) How do salaries, living conditions, etc., in your organization compare with those in industry? (13) What means do you take to assure a high quality of supervision in your organization? (14) What do progress ratings tell you about the quality of supervision in your organization?

III. What information does the administration require concerning jobs in order to plan a satisfactory program of activities? (1) What meaning for you have such terms as *job descriptions*, *job analysis*, *job specifications*, *job evaluation*, etc.? (2) How many specific uses can you identify for job analysis? (3) How does any one service depend upon job analysis? (4) Why is a successful training program dependent in part upon detailed information regarding the involved jobs? (5) When you decide upon an analysis of jobs in your department, how will you select an analyst? (6) When you decide upon an analysis of jobs, how will you prepare your staff?

IV. What responsibility has the administrator for public relations? (1) How does your reputation with respect to training and the opportunities you offer for advancement rate with sources of labor? (2) How do former employees affect your public relations? (3) Have you a planned public relations program? (4) How do you keep employees aware of their responsibility for interpreting the organization to the public? (5) What type of educational program do you plan for board members?

V. What responsibility has administration for the health service of the organization? (1) How does the health service function? (2) What categories of employees are privileged to use the health service? (3) How do you make the health service a truly educational service? (4) How do you select the medical and nursing director for this service?

The Adventures of Bedside Nursing

The consultant for this workshop is presently working on suggested topics. The following excerpt is taken from a letter outlining in general terms her ideas for this workshop:

> We are interested in the nurse-patient relationship and feel it is not stressed sufficiently. Our idea is to have in mind the attitudes desirable in the graduate nurse and then to begin with the new student in the school of nursing and make use of the types of experience throughout her training that will help develop these attitudes to make her a desirable graduate nurse. This would be done through stressing relationships. At the same time we would be following a patient from a home in a community into the hospital situation, through a trying experience requiring definite adjustment, and back to the community with a handicap requiring the use of community resources to help in his rehabilitation, working these together to show the outcomes to each as a result of stressing favorable relationships in the broad sense. Psychological, physical, social and, in fact, every aspect would be included. The aim through this approach would be the long-term view, considering the final graduate nurse. The second phase then might deal with the bedside nurse or graduate of today who will not have developed along these lines. Our problem will be to find ways and means to help her in this approach to patient care.

Job-in-Training

Training on the job is not something new but something that has received more emphasis in the past ten years. When the heads of large industries found themselves called upon to increase production with untrained workers and outmoded equipment, what did they do about it? After more or less delay, industries determined that a way must be found if they were to do the job governments and peoples were expecting of them; they, therefore, called in experts who studied the total situation. On-the-job training versus haphazard on-the-job learning was one of the answers presented by the experts. The method was accepted by management, put into practice, and gave results.

Training on the job is the practical application of good personnel policies and good teaching principles. On-the-job training implies a program planned for the learner by a foreman or supervisor who is expert in teaching and in the skill to be taught; an actual work situation or a situation as nearly resembling the actual job as it is possible to make it; appropriate equipment; and supervision until the worker has mastered the skill taught and is ready to proceed to the next level of performance. On-the-job training is not for any one period of the individual's service, because the worker continues to grow and environmental factors continue to change but, for the purposes of this workshop, job-in-training will be taken to refer to the initial period of training, which will vary in length with the person and skills to be taught.

What are the implications for nursing organizations? Many and varied are the jobs performed in hospitals, nursing schools, and public health nursing organizations, not always to the complete satisfaction of the employer and employee. Have we had such problems as rapid turnover of workers, absenteeism, waste of expensive equipment, etc.? If the problems found in nursing organizations resemble those of industry, might the solution found workable in one situation be equally successful in the other? But, you will say, *we are working with people and people are never twice the same, whereas the industrial worker is working with a machine that always responds in the same way.*

The fact that we are working with people is the very reason that we should give consideration to the methods employed in introducing people to new situations. Will it not improve the morale of the worker when, instead of being thrust into a new situation with maybe a few hurried instructions that, in her excitement, she may fail to understand, she finds the supervisor expects her to need instruction? Will it not raise the status of the job in her esteem when the worker realizes that the supervisor's main function is to help her to understand and become proficient in her new job? This endeavor, from the first moment of employment, to imbue the worker with a sense of her worthwhileness and importance to the organization has a very high training value, because it lends importance to the job and stimulates the individual to want to live up to the expectations of a well-informed and sympathetic supervisor. Maxcy has said: *No aspect of the personnel job better characterizes the real purposes of personnel work than does training—for training works to improve the job done by improving the individual doing the job.*

What, then, are we going to try to do in this workshop? We are going to explore job-in-training methods of instruction and consider the application of these methods to the hospital and allied fields. We hope to have plenty of time for teaching demonstrations and for making job breakdowns. What is a job breakdown? The job breakdown is an attempt to think through the important features of any job and to put on paper (the breakdown sheet) a statement of the several motions that must be taken to accomplish one specific job, together with qualifying comments that emphasize important phases of that job.

Health is not only to be well, but to be able to use well every power we have.

—FLORENCE NIGHTINGALE

Notes du Secrétariat de l'A.I.C.

Congrès de l'Association des Infirmières du Canada

Les dates du congrès nous paraissent encore lointaines, mais bientôt nous y serons rendus et ce sera déjà le 28 juin et le 1er juillet.

Les inscriptions aux cercles, ou foyers d'études, seront reçues jusqu'au *15 mai prochain*. Afin de faciliter l'organisation, l'on est prié de s'inscrire dès maintenant. Des formules spéciales d'inscription peuvent être obtenues de la secrétaire de votre association provinciale. Chaque cercle d'étude doit être limité à 50 membres; les inscriptions seront faites dans l'ordre de leur arrivée. Afin de n'être pas déçues, l'on demande aux infirmières d'indiquer 1er, 2e, 3e choix.

L'infirmière sera le pivot autour duquel toutes les discussions, les travaux des cercles d'études se concentreront. L'étude et la solution des problèmes de l'infirmière seront l'objet d'une attention spéciale; des experts pourront être consultés.

Ce qui suit est un exposé de ce que nous essayerons de faire dans nos cercles d'études:

Relations extérieures: 1. Quels sont les principes à la base d'un bon programme de relations extérieures? Comment vous rendez-vous compte des besoins de votre localité et des besoins de l'hôpital? Par quelles méthodes pourriez-vous faire comprendre au public de votre localité, les services que rend l'hôpital, les conditions favorables qu'on y trouve, la politique ou règle de conduite qu'on y suit?

Comment faire comprendre à l'administration d'un hôpital, les besoins du public? Comment convertir le support moral accordé en un support financier?

2. Quels rapports y a-t-il entre des employés satisfaits et de bonnes relations extérieures? Quel groupe de l'hôpital bénéficiera le plus d'un bon programme des relations extérieures? Comment les employés interprètent-ils la politique de l'hôpital envers les gens qui se trouvent à l'hôpital et aux gens du dehors? Quels moyens employez-vous pour que tous vos employés comprennent bien la responsabilité qu'ils ont à bien connaître et à bien interpréter la politique de l'hôpital? Quels moyens employez-vous pour expliquer les changements intéressant vos employés?

3. Un bon programme définissant la conduite tenue à l'égard du personnel, contribuet-il à amener des relations plus cordiales parmi vos employés et à améliorer vos relations extérieures?

La considération que "tout homme a son amour propre" est-il un facteur important dans les bonnes relations? De quoi vos employés se plaignent-ils le plus? Une louange méritée, peut-elle contribuer au bien-être de l'employé? Comment réagit votre personnel devant l'autorité responsable? Pensez-vous souvent à mettre en valeur l'habilité et les aptitudes spéciales de vos employés?

4. Comment le bien-être des employés peut-il contribuer à la réalisation du but ultime de l'hôpital? Quelles sont les fonctions de l'hôpital et des autres organisations du nursing? Comment vos patients renseignent-ils le public sur l'hôpital et sur les infirmières?

5. Quelle doit être la fonction principale de la personne chargée d'un bon programme de relations extérieures?

6. Pourquoi tout le personnel doit-il être mis au courant du programme des relations extérieures et pourquoi doit-il considérer les relations extérieures comme un des services les plus importants de l'hôpital?

Nouvelles méthodes d'enseignement: Au point de vue de l'éducation de l'infirmière que doit-on penser de la tendance actuelle d'organiser un service de santé régional, l'hôpital étant reconnu comme l'organe vital de ce service de santé?

Après avoir étudié le rôle de l'infirmière dans la société, il a été dit que les sciences sociales devraient occuper une plus grande place dans son éducation. Le programme d'étude de nos écoles, permettrait-il d'ajouter cette matière? Si non, que doit-on faire si ces connaissances sont nécessaires à l'infirmière dans son éducation et dans sa pratique?

Il a été dit que l'infirmière de nos jours doit connaître et bien comprendre la famille et le milieu où vit le patient traité à l'hôpital. Comme moyen de formation dans ce sens, quelles mesures devrons-nous prendre ou quelles expériences devrons-nous donner à nos élèves?

Toutes les compétences en éducation admettent que l'infirmière doit être en mesure de connaître tous les facteurs psychologiques, sociaux, émotionels, spirituels, économiques, et hygiéniques qui ont une influence sur le malade qu'elle soigne.

Comment organiser différents groupes du nursing pour atteindre ce but? Quels moyens,

quelles méthodes, à quelle source pouvons-nous puiser pour donner suite à cette idée? Pour faire progresser cette idée, quel sera le rôle de l'école?

L'enseignement clinique: Au cours du programme d'étude, l'enseignement clinique. Comment — l'homme malade et non la maladie — concentrer l'enseignement clinique sur le malade — l'homme malade et non seulement la maladie?

Comment développer des attitudes professionnelles? Comment enseigner à l'élève à viser à la perfection?

Quelle est la valeur, dans l'éducation de l'infirmière, de la méthode d'enseignement, où toutes les élèves peuvent prendre part à la solution du problème ou sujet à l'étude en autant quelles peuvent y contribuer par leurs connaissances et leur expérience? Peut-on développer cette méthode d'enseignement en tenant compte du programme actuel de nos écoles?

C'est un fait reconnu qu'il faut prendre les gens comme ils sont "même pour en faire des professionnelles." Nos élèves apportent à l'école d'infirmières les préjugés et les attitudes de leur famille. Comment pouvons-nous aider au développement professionnel de nos élèves, afin qu'elles acceptent les malades tels qu'ils sont?

C'est un fait reconnu de nos jours, que "le malade complet" (famille, milieu) doit être le pivot autour duquel converge tout l'enseignement donné à nos élèves dans nos écoles. Comment devons-nous organiser notre programme pour atteindre ce but, en donnant les cours sur (a) la technique des soins; (b) la pathologie; (c) les sciences sociales?

Dans la division des matières enseignées, comment pouvons-nous améliorer notre manière de faire? Mettre bien en évidence les buts que l'on veut atteindre. Par des examens, se rendre compte des connaissances déjà acquises par l'élève sur la matière, choix des exemples, appréciation et correction.

Peut-on développer plus d'habilité dans les conférences? Quelle est la valeur de cette méthode d'enseignement? Quels sont les principes à la base d'une bonne conférence, la technique, le plan, etc.?

Tests et mensurations: Les principes à la base des tests, la participation, l'appréciation, etc. Discussion: Pourquoi des tests? etc. Que doit-on mesurer? etc. Comment faire des tests? etc.

Direction du personnel: Sur quels principes reposent une bonne direction du personnel et quels succès ont rapporté les hôpitaux et les autres organisations, qui ont appliqué ces principes?

Changez-vous souvent de personnel? Si c'est là un des problèmes de votre hôpital ou de votre organisation, comment votre administration peut-elle découvrir la cause de ces changements?

Quelle méthode d'entrevue employez-vous lorsque vous voyez pour la 1ère fois un candidat pour une position? Que doit savoir le candidat concernant l'emploi qui lui est offert? Pourquoi est-il important de voir chaque employé lorsqu'il laisse son emploi? Que faites-vous lorsqu'il y a des plaintes, des absences?

Quelle part des responsabilités prend votre administration concernant le service de santé de votre personnel? Comment ce service fonctionne-t-il? Parmi vos employés, quels sont ceux qui bénéficient du service de santé? Ce service de santé est-il vraiment éducatif? Sert-il à faire apprécier la santé? Comment avez-vous choisi le directeur médical et l'infirmière en charge de votre service de santé?

Les aventures d'une infirmière au chevet du malade: Des suggestions ont été reçues, "Nous voulons connaître les relations devant exister entre malades et infirmières," l'on n'insiste pas suffisamment sur ce point. Ce que nous avons en vue, c'est l'attitude que doit avoir développée l'infirmière, en commençant par l'élève au début et durant son cours.

En se servant d'exemples recueillis durant ces années, l'on pourrait développer les attitudes que l'on désire chez une infirmière.

Apprendre tout en travaillant — Le problème d'une production intense en industrie s'est posé, le remède semble avoir été l'enseignement par un expert à un petit groupe d'ouvriers. Pour appliquer cette méthode au nursing, que faut-il faire? Faut-il avoir un but bien défini? Analyser le travail à faire? Décrire le travail? Qui peut faire l'enseignement? Que peut être enseigné? Evaluer le travail? Faut-il avoir un programme? Quel matériel faut-il employer? Quelle surveillance faut-il exercer? L'élève peut-il passer à un travail plus avancé avant d'avoir réussi un ouvrage plus facile? Peut-on employer ces méthodes employées en industrie, au nursing?

Ce qu'il ne faut pas oublier, c'est que les infirmières travaillent chez des humains, réagissant tous différemment les uns des autres, tandis qu'en industrie l'on travaille sur des machines qui fonctionnent toujours de la même façon.

Le fait de travailler chez les humains est la raison qui doit nous faire considérer les méthodes employées pour préparer les personnes à faire face à une situation nouvelle, etc.

"Il n'y a pas de meilleure politique pour une employée que d'avoir toujours présent à l'esprit que la qualité du travail sera augmenté, en raison de la valeur de ceux qui font ce travail." — MAXCY

Remarques: Ces quelques notes, bien abrégées, vous donneront une idée des intéressantes études et discussions qui auront lieu lors du congrès.

C.N.A. Biennial Convention

BULLETIN OF INFORMATION

Accommodation: All requests for accommodation are to be sent to: **Miss Alma Law, Executive Secretary, New Brunswick Association of Registered Nurses, 29 Wellington Row, Saint John, N.B.**

Since there are no single rooms, persons who wish to room together are asked to make such requests when reserving accommodation. Every effort will be made by the committee to arrange accordingly. Accommodation for the Nursing Sisterhoods will be provided in the Academy Residence.

Rates — $3.50 to $4.00 per day, including meals. Meals will be served in Residence Halls, mainly cafeteria system.

Registration for the Convention may be made on arrival. Registration desks will be open in the different residences on Sunday afternoon and evening. Monday morning and during the week of the Convention all registration will be at Allison Hall.

Information Desk in Allison Hall.

Business Desk (for accounts, etc.) in Allison Hall.

Meetings: Executive Meetings in Beethoven Hall. General Meetings in Charles Fawcett Memorial Hall. Workshops — See special bulletin.

Exhibits: All exhibits, including commercial, educational, *The Canadian Nurse*, etc., will be displayed in the Owens' Art Museum.

Lippincott Lounge will be in Allison Hall, where tea will be served at 4:15 each day.

Dress: Owing to the necessity of moving from one building to another, and with weather changes being most uncertain, it is advisable to bring rubbers and umbrellas. *Bathing caps* might also be included as some of the residence showers are fairly high.

BULLETIN D'INFORMATION

Voyage: Canadian Passenger Association, 437 ouest, rue St-Jacques, Montréal 1.

Autres villes: Voir agences de voyage locales ou chef de gare.

Logement: Toutes les demandes concernant le logement doivent être adressées à: **Mlle Alma Law, Secrétaire, Association des Infirmières du Nouveau-Brunswick, 29 Wellington Row, Saint John, N.B.**

Comme il n'y a que des chambres doubles, les personnes désirant être ensembles sont priées de le mentionner. On fera tout ce qui est possible pour se rendre à ces demandes. Les religieuses infirmières seront logées dans la résidence de l'Académie. Le coût des chambres est $3.50 à $4.00, repas compris. Les repas seront servis dans "Residence Halls" en cafétéria.

L'inscription: Au congrès peut se faire à l'arrivée. Des bureaux d'inscription seront ouverts dans les différentes résidences, le dimanche dans l'après-midi et dans la soirée; le lundi et les jours suivants les bureaux d'inscriptions demeureront ouverts.

Bureau de renseignements à Allison Hall.

Assemblées: Comité de Régies — Beethoven Hall. Assemblées générales — Charles Fawcett Memorial Hall. Cercles d'études — Voir bulletins spéciaux.

Exposition: Toutes les expositions commerciales, éducationnelles, du *Canadian Nurse*, etc., se tiendront au Owens' Art Museum.

Salle de repos Lippincott sera dans le Allison Hall; le thé y sera servi tous les jours à 4:15 h.

Vêtements: On conseille d'apporter un parapluie et des caoutchoucs. Il est bon de se rappeler qu'il faudra sortir pour se rendre d'une résidence à l'autre. *Les bonnets de bain* sont aussi conseillés; les résidences sont pourvues plutôt de douches que de baignoires.

Nursing Profiles

The officers of the International Council of Nurses announce with pleasure the appointment of **Daisy Caroline Bridges,** R.R.C., S.R.N., S.C.M. as executive secretary of I.C.N. to become effective from April 1, 1948.

Miss Bridges received her nurse's training at The Nightingale School, St. Thomas's Hospital, London, later attending the Radcliffe Infirmary, Oxford, for her midwifery training. In 1936-37 she studied hospital administration under the Florence Nightingale International Foundation and in 1937-38 studied in the United States and Canada under a Rockefeller Foundation fellowship. Miss Bridges returned to take the position of resident tutor for the Florence Nightingale International Foundation, which appointment was terminated at the outbreak of the war.

Miss Bridges has had a broad professional experience and a distinguished army record as matron, principal matron, and command matron. She has long been keenly interested and active in nursing affairs, currently serving as president, National Council of Nurses of Great Britain and Northern Ireland; chairman, Executive Committee, London Branch, Royal College of Nursing; chairman, Nursing Service Committee, I.C.N.; chairman, Study Advisory Committee, F.N.I.F. Since the war she has given valuable assistance to the Ministry of Health, England, on the Working Party to consider recruitment and training of nurses. This report was published in September, 1947.

Miss Bridges brings to I.C.N. a breadth of vision, a wide experience, a keen interest in nursing, and a charming personality.

A new and interesting piece of work has been undertaken by **Lyle M. Creelman.** Sponsored by the Canadian Public Health Association and financed by the Kellogg Foundation, a thorough analysis is to be made of public health nursing practice in Canada. Miss Creelman has been named field director of the study.

A Maritimer by birth, Miss Creelman taught school for three years before commencing her undergraduate training at the Vancouver General Hospital. Graduating from the University of British Columbia with the degree of B.A.Sc. (nursing) in 1936, she accepted the position of school nurse in Revelstoke, B.C. She joined the staff of the Metropolitan Health Committee in 1937 and the following year was awarded a Rockefeller fellowship for post-graduate study at Teachers College, Columbia University. Miss Creel-

Otley, London, Eng.

DAISY BRIDGES

Macko, Toronto

LYLE CREELMAN

Charmbury, Saskatoon

AGNES LYDIARD

Graetz Bros. Montreal

EVE MERLEAU

man received her M.A. in administration and supervision in public health nursing in 1939 and returned to Vancouver as supervisor of school nursing. In 1941, she was appointed director of public health nursing with the Metropolitan Health Committee.

Miss Creelman's administrative talents were given full scope when she was appointed chief nurse of the UNRRA organization in the British Zone in Germany. With her broad understanding of health problems she was able to inspire the teams under her direction with noteworthy results. Upon her return to British Columbia, Miss Creelman undertook various studies for both the provincial Department of Health and Welfare and the Metropolitan Health Committee. All of this has given her a very sound preparation for the new study which she has just started.

Professionally, Miss Creelman has played a constructive part in nursing association activities in British Columbia and Canada. She served many years on the council of the R.N.A.B.C. and was chairman of the national Public Health Section from 1942-44. A sports enthusiast, Miss Creelman enjoys her swimming, hiking and cycling. She is a photographer of some merit. The nurses of Canada await with interest and anticipation the results of her new endeavor.

Agnes (Laidlaw) Lydiard has accepted an appointment as assistant registrar with the Saskatchewan Registered Nurses' Association. Mrs. Lydiard is a native of Saskatchewan, having taught in the province for a number of years before she entered the school of nursing of the Winnipeg General Hospital whence she graduated in 1933. Following graduation, she engaged in institutional and private duty nursing until 1937 when she joined the nursing staff of the Department of Public Health. Her most recent activity has been as research assistant with the Health Services Planning Commission in Saskatchewan. Mrs. Lydiard's appointment is significant of the growing activities of this busy association. She is welcomed by the nurses of Saskatchewan to her present office.

Eve M. Merleau has undertaken new and interesting work as provincial director of nursing service with the Quebec Division of the Canadian Red Cross Society. Graduating from Ste. Justine's Hospital, Montreal, in 1928, Miss Merleau joined the staff of the Montreal Health Department immediately. In 1942, she enlisted in the R.C.A.M.C. and proceeded soon afterward to England. In September, 1944, she returned to Canada as Captain (Asst./Matron) at Valcartier and Quebec Military Hospitals. After her release from the services, Miss Merleau obtained her public health nursing certificate at the McGill School for Graduate Nurses and returned to the city health department staff. Being very ably bilingual, she brings to her new work keen interest and an appreciation of the value of nursing service in the small, out-of-the-way corners of this large province.

Helen Estelle Schurman, who for the past three years has been superintendent of the Eastern Kings Memorial Hospital, Wolfville,

HELEN SCHURMAN

N.S., has been appointed superintendent of nurses at the Victoria Public Hospital in Fredericton, N.B. For fifteen years, prior to her appointment in 1945 to the hospital in Wolfville, Miss Schurman had held the position of university nurse at Acadia University. Graduating from the Royal Victoria Hospital, Montreal, in 1926, Miss Schurman received her certificate in public health nursing from the University of Toronto in 1934.

Irene Iola Shaw has been appointed superintendent of the Peel Memorial Hospital, Brampton, Ont. Born and educated in Gananoque, Ont., Miss Shaw obtained her public school teacher's certificate before commencing her nurse's training. She graduated from the Ontario Hospital, Brockville, in 1928, with post-graduate courses in obstetrics and operating-room technique at the Toronto General and Kingston General Hospitals. For seven years, she was assistant superintendent of nurses at her home school, going in 1936 to the Ontario Hospital at Cobourg as superintendent of nurses. In 1943, she became superintendent of Lord Dufferin Hospital in Orangeville. Miss Shaw served a term as chairman of District 6 of the R.N.A.O. She is a member of the I.O.D.E. and has a wide variety of hobbies, including tennis, skating, photography, and needlework.

IRENE SHAW

A childhood dream of **Emily Annie Stewart** is soon going to be realized. Ever since she was a child and heard her father talk of Africa where he fought during the Boer War, she has wanted to go there as a missionary. Miss Stewart graduated from the Stratford General Hospital, Ont., in 1943. Before entering training, she took a three-year course of study at the Toronto Bible College and a second course at the University of Toronto after her graduation. She sailed for Switzerland early in January, 1948, and expects to remain there for nine months, perfecting her French before going to Nigeria for a six-month training course. Then she will go to French Equatorial Africa as a missionary under the Sudan United Missions. We wish her every success in her new field of work.

Lena Mitchell has retired from the position of superintendent of nurses at the Royal Jubilee Hospital, Victoria, B.C., after twenty-one years of faithful service in this capacity. A graduate of the Royal Infirmary, Edinburgh, Miss Mitchell moved to Victoria in 1921. After a brief period of private duty

Robinson Studios

EMILY A. STEWART

nursing she joined the hospital staff in 1923 in charge of the tuberculosis wing, later becoming assistant superintendent of nurses.

Josephine Belle Peters, who graduated from the Vancouver General Hospital in 1916, and was a member of the first class in public health nursing at the University of British Columbia in 1921, has retired from her position as consultant with the tuberculosis division of the Department of Health and Welfare in British Columbia, after serving there for twelve years. Following graduation, Miss Peters joined the staff of the maternity department of her home school until she enlisted with the C.A.M.C. in 1918. During her time as a nursing sister she worked in hospitals in British Columbia. In 1921 she joined the staff of the Rotary Clinic for diseases of of the chest in Vancouver. Later, she became travelling clinic nurse and x-ray technician with the British Columbia Tuberculosis Society, joining the provincial staff in 1935. Miss Peters' retirement will be brightened by her interest in ceramics. She hopes to have her own kiln and devote her time to pottery-making at her home at Yellowpoint, B.C.

Mabel Burdon, who graduated from the Royal Victoria Hospital, Montreal, in 1925, has retired after twenty-two years of service. After graduation, she was in charge of Wards F and L. In November, 1927, she became night supervisor of the Royal Victoria Montreal Maternity Hospital until March, 1935, when she took charge of the Cancer Ward, from which she has recently resigned. Her kindness to her patients and her thoughtfulness for those working with her endeared her to them.

In Memoriam

Helene Anctil, who graduated from the Notre Dame Hospital, Montreal, and received her public health certificate from the University of Montreal, died at St. Hyacinthe, P.Q., on January 20, 1948. For the past five years Miss Anctil had been in charge of the nursing service of the Metropolitan Life Insurance Company at St. Hyacinthe.

Lillian G. Archibald, who for thirty years served as registrar of the Vancouver Graduate Nurses' Association, died in Vancouver on January 25, 1948. A graduate of the Victoria General Hospital, Halifax, Miss Archibald was devoted to the service of the association and anxiety for its welfare filled most of her life almost to the exclusion of other interests. She received the King George V Silver Jubilee Medal in 1935 for "outstanding citizenship." Miss Archibald retired in 1942.

Iris Marie Callan, who graduated from the Grace Hospital, Winnipeg, in 1945, died in Everett, Wash., at the age of twenty-four. Prior to her marriage, Mrs. Callan had worked for one year at St. Joseph's Hospital in Winnipeg and at St. Vincent's Hospital in Vancouver.

Evadene Cotter, heroine of a typhoid epidemic in snowbound railway cars nea Churchill, Man., in 1928, honored in World War I, and a widely known figure of the northland in twenty years of public health nursing, died on January 16, 1948, at the age of seventy-one.

Minnie Dobbie, who had been engaged in private duty nursing in Winnipeg for forty years, retiring about ten years ago, died on January 21, 1948, at the age of ninety.

Margaret (Colvin) Dunn, who graduated from the Royal Victoria Hospital, Montreal, in 1903, died in St. Paul, Minn., on February 3, 1948. After graduation, Mrs. Dunn held positions in Boston, Cleveland, and San Francisco, where she was superintendent of nurses at St. Luke's Hospital. She returned to Canada as superintendent of nurses at the Royal Columbian Hospital, New Westminster, then to a position in the operating-room at Wellesley Hospital, Toronto. After her marriage she went to California to live. Her long and painful illness was borne with great courage.

Emily Holmes, a graduate of the Royal Victoria Hospital, Montreal, in 1901, died in January, 1948. In her early nursing ex-

perience Miss Holmes engaged in private duty in New York City. During World War I she organized industrial nursing work in a munitions plant in Verdun, P.Q. Following the war she was health nurse at the Sun Life Assurance Company, Montreal, in charge of a clinic which she organized. She retired about fifteen years ago and had been in fair health for the past few years.

Eelen (Templeton) Hugill, who was a charter member of the Alberta Association of Registered Nurses, died in Edmonton on January 24, 1948, following a lengthy illness. Born at Smiths Falls, Ont., Mrs. Hugill graduated from the Presbyterian Hospital, Chicago. After taking post-graduate work in obstetrics and maternity she became superintendent of nurses at a Missouri hospital, later working in Montreal. One of the highlights of her nursing career was her attendance at the organization meeting of the Victorian Order of Nurses which was addressed by Lady Aberdeen.

Inga Johnson, who graduated from the Winnipeg General Hospital in 1907, died on January 3, 1948, at the age of sixty-seven. Following graduation, she served on the hospital staff until 1916 when she went overseas with Canadian Casualty Clearing Station No. 4. She was awarded the Royal Red Cross (First Class) and also received an award from the Belgian Government. For some years, Miss Johnson had served as matron of "Betel," the Old Folks home at Gimli, Man.

Margaret Flora Leard, who graduated from the Prince Edward Island Hospital, Charlottetown, in 1940, died on February 1, 1948, as the result of an accident. She had worked on the Provincial Sanatorium staff until she joined the R.C.A.M.C. with which she saw service both in England and on the Continent. Miss Leard was furthering her great ambition to study music at the time of her fatal accident.

Ann MacArthur, who was in charge of the maternity ward at the Calgary General Hospital, Alta., during the early 1900's, died in Victoria, B.C. on January 14, 1948. Miss MacArthur went to Calgary from her native Scotland in 1904, working later in Macleod, Grand Forks, and Nelson. She retired from active duty in 1940.

Agnes (Murray) MacIntosh, a graduate of the 1946 class of St. Joseph's Hospital, Sudbury, Ont., died in California on January 28, 1948. Born and educated in Sudbury, Mrs. MacIntosh was active in sports circles.

Mary E. McPherson, a graduate of the Hospital for Sick Children, Toronto, in 1907, died on December 30, 1947. A nursing sister with the C.A.M.C. in World War I, she served overseas for three years and received the Royal Red Cross. For a time she was on the staff of the Victorian Order of Nurses in Saint John, N.B. In 1920 she was appointed supervisor of the foster homes division of the Toronto Infants Home, a post she held until her retirement in 1937.

Margaret (Bell) Parker, a graduate of the Royal Victoria Hospital, Montreal, in 1929, died suddenly on December 26, 1947, at the age of forty. Following graduation, Mrs. Parker had engaged in nursing in Montreal until the time of her marriage in 1940.

Hazel (Boe) Pritchard, a graduate of the Moose Jaw General Hospital, Sask., in 1944, met her death in a drowning accident involving both herself and her husband.

Catherine Margaret Smith, who had seen service in both the South African War and during World War I, died in Edmonton on January 25, 1948, at the age of seventy-five. Miss Smith took her training in the old country and after her graduation joined the Queen Alexandra Imperial Military Nursing Service. She came to Alberta early in the 1920's. During World War I she saw service in the Dardanelles campaign, Salonika, and other eastern theatres. After her return from overseas she engaged in private nursing until illness forced her retirement four years ago.

Rev. Sister St. Denis, a member of the first graduating class of the Ottawa General Hospital in 1902, died at the Mother House of the Grey Nuns of the Cross on January 2, 1948, at the age of eighty-one. Sister St. Denis practised her profession in the hospitals of Ogdensburg, Mattawa, and Ottawa. In the latter she had served for forty-six years. In 1935 she was awarded the O.B.E. by His Majesty King George V for her service in the nursing field. In 1939 she celebrated her Golden Jubilee on which occasion she was the distinguished recipient of the Papal Medal

and Blessing for her valuable service as a religious and a nurse. The Ottawa General Hospital Alumnae Association also presented her with an engraved gold chalice on that occasion. In 1939 she retired from active nursing service and took charge of the central supply room of the hospital where she rendered valuable assistance until two months before her death. Sister St. Denis was known and loved for her "unselfish devotion to the sick, the suffering, and the dying." She knew no creed, race, or color in her work. "Doctors as well as patients welcomed her presence and frequently sought her advice." Always of a quiet and retiring nature, she shunned all publicity. "She was, in the fullest and truest sense, a Lady with the Lamp, whose wick was human kindness, gentleness, and charity."

REV. SR. ST. DENIS

Marjorie H. (Kinnear) Thompson, a graduate of the Toronto General Hospital, died suddenly at her home in Toronto on January 5, 1948.

Vivien Adlard Tremaine, one of Canada's most widely known nurses and attendant to King George V during his illness in 1915, died on January 26, 1948, following a lengthy illness, at the age of sixty-six. Graduating from the Montreal General Hospital in 1907, Miss Tremaine worked throughout Quebec until the beginning of World War I when she joined the nursing staff of the C.A.M.C. She went overseas in 1914, taking charge of the first Canadian General Hospital. Later she returned to England to attend His Majesty whom she nursed for several weeks. In recognition of her gallant and humanitarian services, Miss Tremaine was decorated with the Royal Red Cross (First Class), the Victorian Medal, given to persons attending His Majesty, and the Florence Nightingale Medal. Demobilized in 1920, Miss Tremaine was in charge of the Red Cross Immigration Service at Quebec, Halifax, and Saint John.

Irma Van Bockstaele died in Fort William, Ont., on January 22, 1948, in her sixty-sixth year. Miss Van Bockstaele received her training in Belgium and came to Canada in 1910. With the declaration of war in 1914, she returned to her native country and became an army nurse. She was decorated several times in her work by the government of her country. After peace was declared she returned to Canada and entered the employ of the Metropolitan Life Insurance Company. For fifteen years she was supervisor of nurses for the company in Montreal. She retired in 1938.

Indicative of the complexity and interrelationship of the causes of mental illness, these may be divided into "predisposing" and "exciting." A predisposing cause does not precipitate the psychiatric disorder. Predisposing factors are those things which render the human soil in which they exist more vulnerable to mental disease. Such factors as the sex of the individual and heredity are now looked upon as relatively unimportant. Actual age may be important as at some ages people seem to be more predisposed to certain illnesses. Environmental factors, both general and personal ones, are of great importance, as are occupational hazards and previous attacks.

No one is without any predisposition, but even the predisposed will escape mental illness unless he comes in contact with an exciting cause at the wrong time of life. Exciting causes may be preponderantly somatic or preponderantly emotional since the functions of the body and mind are so closely entwined and function as a single unit. Any physical illness has immediate repercussions upon the emotional life, and vice versa. However, in the intricacies of mental illness, the somatic causes are insignificant compared to the emotional causes — frustration, disillusion, disappointments — which are woven into the life of every human being.

— DR. EDWARD A. STRECKER

STUDENT NURSES PAGE

Addison's Disease

THE SUPRARENAL GLANDS, lying just above each kidney, are composed of two layers—the cortex and the medulla. Dr. Takamine, a Japanese researcher, discovered the substance secreted by the medulla, adrenalin, which for a considerable time was considered to be the only hormone produced by these glands. Adrenalin causes contraction of the small blood vessels, thus raising the blood pressure. It also dilates the bronchi and increases the blood pressure, thus preparing the body for any emergency action. Very little is yet known about either over- or under-secretion of adrenalin, but it is frequently used clinically for its therapeutic effects. It is not absorbed from the alimentary canal and must, therefore, be given by injection.

The hormone secreted by the cortex of the suprarenal gland seems to be essential for the maintenance of life. This hormone, corten, was found in 1930 by American research workers. A pure, active extract was prepared in 1936 and the following year its chemical formula was discovered. It was called "corticosterone," shortened to corten. This substance helps to control the mineral metabolism of the body, especially that of sodium. Hyposecretion of corten results in Addison's disease, which occurs in a great majority of instances from destruction of the gland by tuberculosis. When tuberculous, it is usually secondary to tuberculosis in some other part of the body. Atrophy of the glands is responsible in other cases.

This disease was first described by Dr. Thomas Addison of Guy's Hospital, London, Eng., in 1855. His book, portraying the condition which now bears his name, was coldly received in that day.

The symptoms which occur in patients with Addison's disease vary but as a rule they include:

Marked weakness and asthenia, abnormal fatigue, lethargy, and the skin and mucous membrances show a dark pigmentation. The symptoms develop slowly and insidiously, often beginning with insomnia and anorexia. There may also be vomiting, constipation, abdominal pain, diarrhea, salt craving, and muscle pains. The patient becomes very sensitive to heat and cold, and is likely to be anemic with low blood sugar and an increase in the blood urea. The sodium in the blood is markedly reduced while the potassium is increased. The blood pressure is low and the output of urine is decreased. The disease occurs chiefly in adults from twenty to fifty years of age. Males are apparently slightly more susceptible than females.

The disease runs a chronic course with exacerbations and remissions, but untreated is usually fatal within three years. The changes which occur may be great enough to cause a "crisis." The signs of this are extreme weakness, faint or imperceptible pulse, low blood pressure. Coma and death may result in a short time if emergency treatment is not instituted promptly.

The injection of cortical extract relieves most of the symptoms, but it has to be continued indefinitely and potent extracts are very expensive. Preparations given by mouth exert no effect since the hormone is not absorbed from the alimentary

canal. Many patients with Addison's disease show nearly as great an improvement when given large doses of common salt by mouth as when given cortical extract by injection. Vitamin C is used as an adjunct in treatment.

Addison's Disease and Cardiac Failure

MARGARET C. APPLEWHITE

MRS. R. WAS a very attractive, tiny person who endeared herself to all with whom she came in contact. She was very happily married to a school teacher who was devoted to her and who left nothing wanting in the path of her happiness. Their home was beautiful and modern. It was in the city suburbs high on a hill overlooking forest and river. Both Mr. and Mrs. R loved children though they had none. Mrs. R was thirty-seven years old but she was so small it scarcely seemed possible that she should be that age. She was intelligent although, as this account progresses, you will note how her disease affected her mind.

Prior to being admitted to the hospital with Addison's disease, Mrs. R had had several illnesses—a productive cough for which there seemed to be no cause, a second degree sunburn, and scarlet fever. She had lost weight, felt tired, and complained of pain in the right lower quadrant. In two weeks she lost five pounds and had two attacks of gastro-enteritis, so the doctor advised hospitalization.

On February 18, Mrs. R, because of weakness, loss of weight, nervousness, moderate tremor of her outstretched fingers, and abdominal pain, was admitted for x-rays and observation. The provisional diagnosis was hyperthyroidism. Her appetite was fair, her bowels and menstrual periods were regular but she had suffered pain of late with the latter. Mrs. R's face was thinner than normal and somewhat browner, her heart and chest were within normal range, and the exposed surfaces of her skin showed darkened pigmentation. A gastro-intestinal x-ray series showed mucosal ulceration in the region of the duodenum. Blood tests were done and the results were as follows: Sedimentation rate, 24 min.; normal for women, 0.22 min. Coagulation time, 4½ min.; normal, 2-8 min. Hemoglobin, 91%. Platelet count, 230,000; normal, 250,-000; W.B.C., 5,800; normal, 5-9,000.

During her stay in hospital a basal metabolism test was given and it was within normal range. On February 23, Mrs. R was discharged unimproved. Her weight was now only 98 pounds as compared with 107 pounds the month previous.

Mrs. R was re-admitted March 1 because of general malaise. Re-examination showed nothing further excepting that her skin was bronzed over the entire surface, the exposed face and extremities being more marked. For a week following admission she was treated by means of intravenous glucose in saline because of nausea and vomiting. Mrs. R complained of insomnia and a sedative of Seconal Sodium gr. 1½ was given at bedtime with a hot drink. Very little nourishment or any other medication was given by mouth. Ten days after admission her blood pressure was 70 systolic and the diastolic could not be obtained. The day previous she had been started on a sippy diet because of upset digestion and previous diagnosis of superficial duodenal ulcer. When Mrs. R was allowed to drink, it was with difficulty that we persuaded her that the fluids

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Mrs. Applewhite has recently completed her training at the Brantford General Hospital, Ont.

offered would not disturb her digestion. She was seen in consultation by another physician and the diagnosis of Addison's disease was considered. The next day Mrs. R was in an acute Addisonian crisis—her blood pressure was so low it could not be obtained, pulse was imperceptible, extremities and lips were markedly cyanosed and the patient looked as though she were doing to die. An intravenous cut-down was started on her right ankle because the veins in her arms had collapsed from so many previous intravenous injections. She was given large doses of Adrenal Cortex in 2000 cc. of 10% dextrose in isotonic solution of sodium chloride.

The change in Mrs. R after administration of Adrenal Cortex was amazing—she became conscious, more active, mental apathy subsided, and pulse and blood pressure were accelerated. The next day her systolic blood pressure was 70 and a saline intravenous of 2000 cc. was continued daily, also Adrenal Cortex q.4.h. Three days after the crisis, Mrs. R's blood pressure was 85/60. On the evening of March 14, the intravenous was discontinued because of the development of phlebitis in her leg, temperature was elevated to 103°, and there were red streaks up her leg and thigh. Treatment consisted of absolute rest and a heat cradle. Mrs. R was very co-operative and as her leg was painful we told her exactly what phlebitis was and its prognosis. She seldom moved that leg any more than was absolutely necessary. The condition markedly improved. After the intravenous feedings were discontinued Mrs. R was put on sodium chloride tablets, *per os*, and this presented a problem which we had to overcome. These tablets made her nauseated and to allay this we used to put them in junket or custard. A week later we were able to procure sodium chloride enseals gr. 15½ and two of these were given q.i.d. By March 28 Mrs. R had gained two pounds and on this day we began administration of Desoxycorticosterone Acetate in oil, 1 cc. daily, given intravenously. This is a synthetic preparation of the active hormone of the adrenal cortex and it came in 10 cc. ampules containing 5 mgm. per cc. under the proprietary name Percorten. Her weight record showed very little variation from day to day. Once more the physician ordered blood counts to be done and this time Mrs. R's hemoglobin was down to 68%, R.B.C., 3,960,000, which is certainly very much less than on her previous admission. No doubt this was due to the increase in the plasma volume.

Our patient continued to make very good progress and was soon out of bed sitting in the chair. Her skin was still bronzed but the mental apathy was improved as was the insomnia and her appetite. During the first week of April, Mrs. R's temperature started to rise suddenly—the cause, a reddened area in the right posterior gluteal region. This was incised under ethyl chloride surface anesthesia and the purulent exudate drained. Sitz baths were ordered to help promote healing and drainage and reduce the inflammation. Mrs. R enjoyed these baths twice a day very much. They were quite a treat after continued bed baths. The elevation of temperature that resulted from this infection soon subsided and on April 10, with a blood pressure of 100/70, Mrs. R was discharged a happy, improved, and very thankful woman.

I visited her many times while at home and she seemed to be doing very well on a daily injection of 1 cc. Percorten and 31 gr. sodium chloride enseals t.i.d. The one thing that bothered her was her rapid weight change from day to day even though it was only two to three pounds. Another thing was her mental sluggishness as she was aware that she could not remember things. I tried to reassure her as much as possible and thought at times I was successful.

Mrs. R led a fairly limited life after returning home for she stayed in bed until noon and then just puttered around. She seemed to take a special delight in the gold-fish in the pond and the tiny baby rabbits. She still did

not sleep as well as before this illness though it had improved somewhat. A week prior to admission for implantation of Desoxycorticosterone Acetate she had some dizziness and was found to have high blood pressure. On the evening of June 17, I admitted Mrs. R for surgery. The skin was prepared with the antiseptic Merthiolate. The operation was a very simple one. The incision, one inch long, was made in the right post-axillary line about the level of the inferior angle of the scapula and was deepened into the trapezius muscle. Six 75 mgm. pellets of Desoxycorticosterone Acetate were inserted. Mrs. R was cheerful about this because after all it meant not having to have the daily injections. Three days later she was discharged and did moderately well until early in July when her blood pressure soared to great heights. The heart sounds were not of good quality, she did not feel as well as usual, and her ankles were edematous. Suddenly on July 7, 1946, Mrs. R died. The wear and tear had worn her heart out.

Mrs. R never dreamed she had Addison's disease and for a long time she thought that it was the duodenal ulcer causing all the trouble. It was difficult to go into her room and act as though you did not know. Many times I felt tempted to say something but held it back knowing that her physician must have a good reason for not telling her. She was a patient, kind person and we had no difficulty as far as treatments were concerned.

I had never seen a case of Addison's disease before and have not seen one since. All I knew about Addison's disease was that it was a deficiency of corten from suprarenal glands. It was most interesting to find out about it, watching the build-up to the crisis and the rapid way in which the corten works.

Addison's Disease and Tuberculosis

FRANCES E. CUNNINGHAM

AN INTERESTING CASE is that of a negress, aged 26 years, who had signs of adrenal crisis when Addison's disease was first suspected. In general, her history is as follows—she felt well until after her third and youngest child was born in March. Treatment was required for postpartum shock. After that time she felt weak and dizzy and had no appetite. At times during the following year there was nausea, vomiting, and pain in her stomach. In May, 1946, in addition to these symptoms, there was chest pain, cough, and pain in her legs. Her weight had dropped from 216 to 164 lbs.

In May, 1946, a chest x-ray showed what resembled pneumonia of the right lung. Sulfa drugs were given. The sputum was negative for tuberculosis. Two months later, July, 1946, a swelling about the size of a lemon developed about the right clavicle. The aspirated fluid showed numerous acid-fast bacilli, which are often though not always tubercle bacilli.

Because of this and because there was very little change in the chest condition from May to September, she was admitted to the tuberculosis hospital in October, 1946.

The chest x-ray at this time showed moderately advanced tuberculosis on the right side. Her complaints were cough, sputum, and draining sinus above the right clavicle. Sputum was negative on direct smear, but positive for tubercle bacilli when cultured on Jensen's media; hemoglobin, 60%; white blood count, 6,900; urinalysis showed nothing abnormal.

Miss Cunningham was on the staff of the Tuberculosis Hospital in East Saint John, N.B., when she studied this case.

Her temperature was 100.4° and was markedly elevated for about two and one-half weeks—on two occasions reaching 104°. Pulse ranged from 90-132. Vomiting occurred several times during the first two days.

During routine examination, two days after admission, no blood pressure readings could be obtained and the patient's feet were very cold. Shortly after and following the next meal there was nausea, vomiting, and pain in the epigastric region. Pulse was very weak and rapid.

An intravenous of 1000 cc. of 5% glucose and saline was begun, but with difficulty because the veins were collapsed. Adrenal Cortex extract 1 cc., s.c. q.2.h. was also given.

After twenty-four hours, blood pressure was raised to 86/70; pulse was stronger and the patient felt generally better though still weak. She was washed, fed, and kept at rest as much as possible while acutely ill. Light diet was given and the taking of extra carbohydrate was advised though not forced, as the patient had no appetite for sweet foods and became nauseated easily. Multiple vitamin tablets were given b.i.d. with meals.

Sodium chloride gm. .1 was also given with each meal and q.h.s., then reduced to three times a day. Specially coated "enteric" tablets were used after the patient found difficulty in tolerating the uncoated tablets.

The giving of extra salt, though not absolutely necessary, helps maintain the normal amount in the blood and less hormone is required. Edema must always be watched for and, if it develops, the sodium chloride is stopped for a time or the amount of hormone reduced.

Diagnosis of Addison's disease was not definite because the toxemia of acute active tuberculosis could be responsible for many of the symptoms. Because of the uniform blackness of the skin no unusual pigmentation could be seen, and pigmentation of the mucosa of the mouth (another diagnostic aid) is natural in negroes. The blood chemistry was not abnormal enough to be characteristic. However, the patient was improving with the treatment being given, so it was continued.

Adrenal Cortex extract 1-2 cc., q.2.h., q.3.h., or q.4.h., according to the patient's condition, was given for about two weeks. In this time, blood pressure readings were taken at least once a day and were between 86/70 and 64/50. There was vomiting several times.

After these two weeks the hormone was given in different form. Desoxycorticosterone Acetate in sesame oil was used—trade name Percorten.

Percorten 5 mg. intramuscularly was given daily, and the dose gradually cut down until the daily maintenance dose was found to be 3.5 mg. This took about ten weeks. The blood pressure was still taken daily and kept approximately between a systolic pressure of 120 to 100, and the diastolic pressure 90 to 70. The dosage of Percorten was prescribed to be given daily after blood pressure was taken. Blood chemistry was done at intervals as considered necessary. Hemoglobin had increased from 60 to 92 per cent in two months' time.

In these ten weeks of treatment with Percorten the patient had very little vomiting; occasionally had abnormal coldness of the extremities; headache; and dizziness when sitting up in bed. But on the whole she looked and felt better and appetite had improved.

It was now time to find out if Percorten therapy was still needed. To this end, as an aid in diagnosis, the Percorten and sodium chloride were stopped completely. The patient was watched for symptoms such as anorexia, muscle weakness, nausea, vomiting, coldness of the extremities, faint pulse, etc. Blood pressure was taken twice a day. Within a week the blood pressure had fallen to 80/60; pulse was weaker; extremities cold and damp; there was abdominal pain, and vomiting once. These symptoms did not all appear immediately, but over several days. Evidently hormone treatment was still needed.

Adrenal Cortex extract 1 cc., s.c. q.2.h., for two doses was given in addition to Percorten 5 mg. intra-

muscularly. Adrenal Cortex extract acts more quickly than Percorten.

Percorten 5 mg. intramuscularly daily and sodium chloride as before were given. In about two months the maintenance dose of Percorten was established at 3 mg. daily. This will be continued as long as the patient has active tuberculosis and has no toxic symptoms from Percorten.

In April, 1947, the chest condition had improved somewhat, and the draining sinus was almost completely healed. There had been no vomiting for two months. The patient was cheerful and accepted treatment without complaint or protest. If the tuberculosis were controlled sufficiently to become inactive and the patient well enough to go home the following treatment would be given:

To relieve the necessity of having intramuscular injections daily, a subcutaneous implantation of Percorten pellets would be done. The site is infrascapular. In a transverse incision, several pockets are made with blunt dissection. The pellets are dropped gently to the bottom of the pockets. Great care must be taken not to crush the fragile pellets. The pockets must be deep enough, 2 to 3 cm., to prevent the pellets from being extruded later through the incision. The incision is closed with fine black silk.

One pellet of 125 mg. is needed for each .5 mg. of hormone required daily. "Sixty per cent of the intramuscular maintenance dose is found to be adequate in pellet implantation."[2] Absorption is slow and continuous. Effective therapy is provided in most patients for a period of at least a year.

When the patient shows signs of adrenal insufficiency, the maintenance dose must again be found before the implantation of more pellets. If overdose symptoms appear, one or more pellets may have to be removed. If more hormone should be required, as in acute infections or pre-operatively, intramuscular injections of Percorten, glucose and saline intravenously, and Adrenal Cortex extract s.c. would be given.

"Patients with Addison's disease are extremely poor surgical risks."[1]

Another way of giving the hormone is by sublingual tablets with absorption through the salivary glands. This is effective, but much more hormone is needed, and the cost of an already expensive treatment is greatly increased. Also, uniformly continuous absorption is harder to obtain than in the other methods.

The disadvantage of Percorten is that "it does not represent complete replacement therapy."[2] The disturbance in carbohydrate metabolism is very slightly affected and hypoglycemia may occur at any time during treatment. Hypertension, peripheral and pulmonary edema, and cardiac failure may also occur.

Hypoglycemia may be avoided by increasing the carbohydrate intake, especially after unusual exertion.

Percorten is a very potent hormone and hazardous when not carefully used. The patient may die of the disease if too little is given, or of the hormone effects if too much is given. Those taking the hormone in any form and by any method should be seen by the doctor for examination at fairly frequent intervals. Any deviation from usual health should be reported.

Before specific therapy with the synthetic hormone was used, the outlook for patients with Addison's disease was very gloomy. Most of them were invalids with no chance of recovery or improvement in health.

Since the use of specific synthetic hormone therapy, many have been able to return to their previous and normal occupations.

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Conference on Rheumatism and Arthritis

ETHEL CRYDERMAN

Last spring during the debate in the House of Commons on the estimates of the Department of National Health and Welfare, the Honorable Paul Martin, Minister of Health and Welfare, announced that, at the suggestion of the Canadian Rheumatism Association, he proposed to convene a conference of representatives of various organizations and groups interested in the problem of rheumatism and arthritis in Canada. The attention given this announcement by the members of the House of Commons was indicative, not only of the significance of this problem, but of the keen interest of a group of elected representatives from all parts of Canada in tackling a problem which affects such a large percentage of the population.

The conference on Rheumatism and Arthritis was held on October 13 and 14, 1947, at the Department of National Health and Welfare, Ottawa. The purpose of the conference was to consider all phases of the problem of rheumatism in Canada and to study the question of the formation of a Canadian society which would further research and stimulate the expansion of facilities for the diagnosis and treatment of this disease. Representatives were present from the Department of National Health and Welfare, the medical faculties of the Canadian universities, the provincial departments of health, and national voluntary organizations interested in this problem. The sessions were chaired throughout by the Honorable Paul Martin. Mr. Martin's interest in this subject, his recognition of the extent of the problem, his conviction that immediate action was required, and his ability as a chairman meant much to the successful outcome of the conference. As a background for general discussion, information was first presented regarding the general rheumatism problem in Canada and the program for the treatment of arthritis in Department of Veterans Affairs hospitals. At the second session, the conference divided into two groups, one to consider ways and means and the other to consider the educational and research aspects of the subject. At the third and last session, following the discussion of the reports of the smaller groups, resolutions were passed.

It is to be noted that in the report of the conference, although the word "rheumatism" in its broadest sense covers all forms of this disease, almost invariably the words "rheumatism and arthritis" are used. The significance of the arthritis problem explains the emphasis on this form of rheumatism. It was also recognized that if an appeal were made to the public for funds, the word arthritis would convey real meaning to potential contributors.

It is only possible to give a very brief summary of the main points presented regarding the situation in respect to rheumatism and arthritis.

The extent of the problem is tremendous. The United States Public Health Service has stated that of all diseases it ranks first in prevalence, second in temporary disability, and third in permanent disability. A survey in Massachusetts has shown that there are more cases of chronic rheumatism today than heart disease, tuberculosis, and cancer combined. The toll of pain is incalculable. The economic damage in sick pay, lost wages, and the cost of medical treatment assumes very large proportions. In England and Wales a conservative estimate is twenty-five million pounds a year. In Canada relatively little survey work has been done on the incidence of rheumatism. It has been stated, however, that a cautious estimate of the number of cases is between five and six hundred thousand.

Research, diagnosis, and treatment: Although there is certain knowledge regarding the causative factors of rheumatism, the nature of the agent is still unknown and the medical authorities at the conference emphasized the need for intensive research on this subject. However, attention was directed repeatedly to the fact that if early diagnoses were made and appropriate known treatments applied promptly, there would be a high percentage of recoveries as well as a great reduction in the present serious crippling of patients suffering from this disease. Diagnostic and treatment centres in Canada are

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Miss Cryderman, superintendent of the Toronto branch of the Victorian Order of Nurses and first vice-president of the Canadian Nurses' Association, represented the C.N.A. at this conference, the only woman member.

woefully inadequate and the urgent need for the development of such centres was one of the keynotes of the conference.

The training of personnel: The necessity for special preparation for medical, nursing, therapeutic, and other personnel, who are associated with patients with rheumatism in its various forms, received considerable attention. It was unanimously agreed that post-graduate courses and internships in arthritis centres, especially those in connection with a medical school, should be made available and that fellowships should be established.

The program of the Department of Veterans Affairs: A description was given of the program for the study of the treatment of arthritis at Sunnybrook, one of the Department of Veterans Affairs hospitals. It was an example of what adequate facilities could accomplish as well as an illustration of the educational possibilities of a well-planned program. Internists are employed on a part-time basis and are members of the teaching staff of the University of Toronto. There are also full-time internes who are studying arthritis as part of their training in internal medicine. Treatment facilities are comprehensive and, through the use of other departments in the hospital, such as occupational, recreational, rehabilitation, social service, and educational, the various wants of these patients can be supplied. In addition, an arthritic patient in a Department of Veterans Affairs hospital is relieved of anxiety concerning the financial needs of his family. As a result of a fully adequate service, the recovery incidence of patients with arthritis is Sunnybrook, as well as other similarly equipped hospitals under the Department of Veterans Affairs, is high.

A plan for national action in Great Britain: Repeatedly throughout the conference reference was made to this plan and this report would seem incomplete without at least a brief mention of one of the important proposals contained therein. The main objective of the plan is "to make it possible for every sufferer, and most importantly every early sufferer, to have facilities for diagnosis and early treatment." To implement this objective, it is proposed to establish special treatment centres in conjunction with teaching hospitals. In conveniently accessible places there would be local treatment centres, each of which would work in close co-operation with a special treatment centre. It is hoped that this plan will be the prototype of the plan promised by the government under the National Health Act. It was felt that in studying the problem valuable assistance could be received from the British plan.

Both of the groups mentioned earlier in this report — the one to study ways and means to establish a national society interested in rheumatism, and the one to consider the research and educational aspects of rheumatism — returned to the general session prepared to support a resolution to organize a Canadian society. Each group had recommendations to refer to the society when organized. The questions of grants and the receiving of funds were left for the consideration of the new organization. It was felt that the following resolution, which was passed unanimously, allowed sufficient leeway for the suggested society to fulfil its function:

"Recognizing that rheumatic disease in its various forms causes grave suffering and loss to the Canadian people, and recognizing that present knowledge in regard to its diagnosis and treatment is inadequately applied, and recognizing that more knowledge regarding its origin, prevention, and treatment is urgently needed, be it therefore

"*Resolved*, That there be established The Canadian Rheumatism and Arthritis Society. The objectives of the society shall be to promote furtherance of: (1) prevention; (2) diagnosis; (3) treatment; (4) training of professional personnel (including fellowships, etc.); (5) research; (6) public education; (7) the raising of funds.

"And to do such other things as will promote the aims and objects of the society and to co-operate with other appropriate bodies.

"And, *Be it further resolved*, That in promoting the foregoing objectives proper advice be taken from competent authorities.

"The ordinary membership of the society shall include individuals and organized bodies in Canada and provision may be made for honorary membership for people outside of Canada."

An interim committee was appointed for the purpose of preparing a charter and by-laws and for the reconvening of the conference. Your representative is a member of the interim committee.

A man too busy to take care of his health is like a mechanic too busy to take care of his tools.
—CICERO

Book Reviews

Three Centuries of Canadian Nursing, by John Murray Gibbon, in collaboration with Mary S. Mathewson, R.N., B.S. 505 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Illustrated. Price $4.00.

Reviewed by Grace M. Fairley, former president of the Canadian Nurses' Association, Vancouver.

This volume, so long awaited by the nursing profession in Canada, has been received with interest and appreciation. It is true that this history is the first Canadian record of nursing to be published and for that the nurses of Canada are grateful. It is long overdue and to Miss Mary Mathewson and Mr. Murray Gibbon goes the thanks of all nurses in this country.

How true, as stated in the chapter on the introduction of training schools, "the history of nursing in Canada cannot be properly considered except in relation to the history of the country." This the authors have recognized fully and it no doubt accounts for what may seem at times to be a lack of continuity in sequence — was not the development of nursing in Canada indeed sporadic?

There is a wealth of information and records which is enlightening and stimulating but the reader feels a certain lack of the enthusiasm, warmth, and romance of those who played such a magnificent part in the development of nursing in this great dominion, and one would refer again to that opening statement in chapter twelve which shows how very young is this country of ours.

On the publisher's blurb is a reference to the skill and devotion of "professional nurses" of French Canada while "England tossed under the shaking hands of Sairey Gamp." We must not confuse the faithful service which characterized the nursing of that era — seventeenth to nineteenth centuries — with "professional training" or must we think that the equally faithful service given by non-religious groups during that period was entirely or even largely given by women of the Sairey Gamp type.

The volume is greatly enhanced by illustrative material and the research and detail collected from so many and varied sources immediately calls forth the gratitude of Canadian nurses to Miss Mathewson who was responsible in no small way for its collection.

It is excellently indexed and, quite apart from its interest as a narrative of one of Canada's greatest public services, it should be used extensively as a reference in all nursing schools and organizations and should find a place on every nurse's bookshelf. It is hoped that records will be kept by all provincial associations so that the profession may look forward to the publishing of a second volume in the not too distant future.

Law and the Practice of Nursing, by Nettie D. Fidler, B.A., R.N., in collaboration with Kenneth G. Gray, K.C., M.D. 106 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. 1947. Price $2.00.

Reviewed by Eileen C. Flanagan, Supervisor, Montreal Neurological Institute.

It is always a matter of interest and importance to the nursing profession when a book is published by a nurse, either alone or in collaboration, for we have been slow in putting into print the great fund of knowledge and experience the profession possesses.

In this valuable little book we find collected important information relating to the nurse's individual position as a legal entity, to her position in relation to the medical profession, to patients, to hospitals, to drug control, and to official public health and nursing organizations. The growing tendency, also, for legislation relating to health insurance and labor relations to involve and affect the nursing profession is forcefully shown in a detailed description of the draft bills relating to these two fields. Instances are also given of the application and attempted application of some of the labor legislation.

The chapters on Drug Control and Mental Illness should prove of very practical value to all those teaching nurses and to practising nurses themselves.

In the last two chapters of the book there is a considerable amount of information relating to the official nurses' associations — international, national, and provincial — and to the provincial registration acts and their influence on nurses, individually and collectively. It will be a matter of opinion as to whether some of the material here presented should not be more properly recorded in a history of the Canadian Nurses' Association. There are several pertinent inferences which

the authors make. It would seem from the comparison of the legislation in the various provinces that the tendency in some of the western provinces is for the universities to virtually control the profession, in two others for the government to do so, and the professional associations in the rest.

It is also inferred that greater authority should lie with the national association executive since the majority of members in any case are provincial representatives. This matter, however, would seem to be a matter of policy of the associations concerned, as it is not in any way laid down in legislation, and one wonders whether the discussion should be included in this volume.

Quite properly it is pointed out that a legal definition of nursing is urgently needed for it would help to solve many problems, although there is no doubt that it would engender new ones. It is also pointed out that a definite policy on labor relations would not only ease the burdens, but also strengthen the hands of both the national and provincial associations.

Finally, there are one or two corrections which might be made in a second edition. In the statement concerning the publication of the volume "Three Centuries of Canadian Nursing," the name of the nurse co-author, Miss Mary S. Mathewson, R.N., B.S., has been omitted and the title of the book itself is incorrect.

In the paragraph regarding the wartime Federal Government Grant, it is stated that the grant was allocated to the provincial associations on the basis of the number of nurses they were producing, while in fact it was allocated on the basis of the number of graduate nurses in the province. The provinces in turn allocated their share to the schools of nursing on the basis of their increased enrolment of student nurses. One questions whether this particular discussion is relevant to the matter in hand.

It is important to make an observation in regard to the statement in Chapter 2, relating to nurses giving or not giving anesthetics. The inference appears to be that there is neither any legal permission nor legal prohibition anywhere in Canada. While it may be so interpreted, it is a fact that, at least in the province of Quebec, nurses cannot give anesthetics since the right to do so is, in practice, reserved solely to medical practitioners under the Quebec Medical Act.

It is to be hoped that this book will be kept up to date and reprinted from time to time; that the material on nursing legislation will be co-ordinated and presented in a purely factual manner, for it is becoming more and more important for all members of the profession, as well as many others, to have access to this material.

Community Clinics, The Hospital Outpatient Department and Nonhospital Clinics, by Loretta I. Bigley, R.N. 276 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. Illustrated. Price $4.25.

Reviewed by Lillian MacKenzie, Director of Public Health Nursing, Winnipeg Health Department, Manitoba.

"Community Clinics" the author states is "not a text on laboratory technics or nursing procedures as such, but is an introduction to clinic work and a guide in setting up and operating such clinics. The term clinic is used here in the broad sense of health workship . . . established for the purpose of diagnosis, the prevention of disease and the treatment of ambulatory patients."

The book is divided into three major parts: Part I outlines the organization and administration of out-patient department clinics and related services. Part II is devoted to classification, grouping, and equipping clinics, as well as the nursing procedures required in the out-patient clinics. Part III deals briefly with the educational values of the out-patient department and the opportunities the department presents in integrating health into the basic curriculum of schools of nursing.

In addition to hospital clinics the author discusses welfare clinics functioning under official and non-official agencies—for example, child health centres.

The volume is heavily illustrated with diagrams of clinic set-ups, techniques, equipment, and records. Teaching guides for nurses are outlined under special clinic services.

As an introduction to clinic work, it is disappointing that more emphasis was not placed on the techniques of referral, the coordination of hospital clinic activities with other community activities, and the value of the clinic as a research centre.

As a tool for assisting in conducting or reevaluating clinic services, "Community Clinics" will prove of great value. Professional workers concerned with hospital and community clinic activities will find it a handy reference.

Parageusia

Early textbooks classified taste and smell together because of their response to chemical stimuli and because of the subjective difficulty of distinguishing between them. However, modern science has demonstrated several fundamental differences:

1. Taste is a response solely to a liquid. No dry substance taken into a completely dry mouth can be tasted. It must be introduced in the form of a solution or dissolved in saliva to arouse sensation. For this reason the taste end organs are located on moist surfaces.

Smell is a response solely to a gas.

2. Taste receptors consist of two elements, i.e., end organs to receive the stimuli and afferent fibres with centrally placed ganglion cells.

Smell receptors are primitive in type and serve as both receptors and conductors.

3. Taste fibres reach the brain via mixed cranial nerves (7th, 9th, and 11th) which conduct somatosensory impulses. Fibres carrying smell ascend directly to the cortex in the unmyelinated olfactory nerve, which is devoted exclusively to that function.

Difficulties in separating one sensation from the other are due to the fact that these two senses are educated simultaneously during growth and development. Through experiments, it was learned that four distinct primary taste sensations exist, i.e., sweet, salt, bitter and sour or acid. Subsequently, it has been found that taste sensations could be aroused both by substances coming into direct contact with the taste buds and by substances reaching the taste buds in the blood stream. Thus, parageusia, or bad taste in the mouth, may be experienced in a great variety of diseases. The disagreeable taste alterations in various diseases, particularly genitourinary diseases, are due to metabolic disorders with hematogenous stimulation of the taste end organs by retained nitrogenous waste compounds or other toxic substances which attain a sufficiently high concentration in the blood stream to exceed the individual taste threshold.

— Dr. S. Lerman in
The Urologic and Cutaneous Review

Early Ambulation

Since 1941, early ambulation has become more widely accepted and followed. Reports now are available from a great many clinics and hospitals and they are generally favorable. The conclusions indicate that early rising following surgery has definite benefits.

It decreases vascular and pulmonary complications, stimulates intestinal peristalsis and spontaneous urination. It does not increase the incidence of wound suppuration and hematomas or wound infection. It builds up the morale of the patient and speeds his convalescence. Nursing care is reduced markedly and there is increased economy for the patient.

Contraindications to early rising following surgery are: general bacterial peritonitis, debility and weakness to a marked degree, serious hemorrhage, coronary thrombosis occurring post-operatively, thyroid crisis, and non-fatal pulmonary embolism.

In the Good Old Days

(*The Canadian Nurse*, April, 1908)

"Last year between six and seven hundred children were treated in the various wards of the Winnipeg hospitals, so a movement has been started in that city towards the establishment of a hospital for children only."

"The House of Mercy Hospital has issued a notice to the effect that only those paying $15 or more a week can be private patients and have the privilege of employing their own physician. The former price was $10 per week."

"A new $50,000 building is to be erected for the Jubilee Hospital, Vernon, B.C."

Isabel M. Stewart's fine article on "The Private Nurse in Her Relation to the Family" was the feature story. The ideal nurse is described as:

"She is plain flesh and blood and to be quite frank she does not monopolize all the virtues. She possesses the essential qualifications of all good workmen — intelligence, technical skill, honesty — but besides she is kind, sweet-tempered, and of a broad humanity. She possesses the inestimable gift of common sense, and that next best shield against the rude knocks of life — a sense of humor. She is not over-burdened with an inconvenient respect for 'the proprieties,' and is capable of tackling a very

a word to the wise . . .

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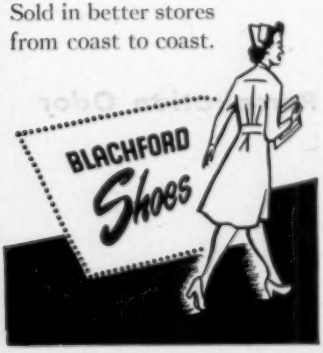

unpleasant situation with a quiet dignity that disarms embarrassment and defies suspicion."

"An important part of the teaching of nurses should be the doing of simple little duties in a refined manner. Trained nurses should be able to do such things differently and, in every home they enter, should teach by example the better, the refined way. There is a tendency on the part of some nurses to grow careless about these little refinements of nursing, after they leave the hospital, because they think no one notices or cares. There are very few details about the way a trained nurse does her work that are not observed and commented on in the average home."

Alberta

The following are recent staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Lucille Laferrière* of Joussard (Misericordia Hospital, Edmonton) to Tangent; *Rhea Laferrière* of Joussard (Edmonton General Hospital) to Valley View; *Sarah MacIntyre* of High Prairie (Edmonton General Hospital and University of Alberta course in advanced practical obstetrics) to Dixonville; *Mrs. Alice Murphy* to Lindale; *Lillian White* to Worsley; *Marguerite Weder* to Fort Assiniboine.

Leave of Absence: *Mrs. Helene Jansen*, from Plamondon, to recruit district nurses.

Resignations: *Mrs. Almeda Kristensen* from Dixonville; *Mrs. Mary Taylor* from Worsley after more than six years' service; *Mrs. Marie Lessard* from Tangent after four and a half years' service; *Margaret Davis* from Brooks, after more than four years' service in public health work in Alberta, to go east; *Mrs. Camilla Hudson*, at Spirit River for over two years, to go to Yellowknife.

Canadian Red Cross

The following are staff changes in the provincial divisions of the Canadian Red Cross Society:

Alberta: *Gwendolyn Saunders*, of the Junior Red Cross Hospital, Calgary, is on leave of absence at the University of British Columbia. The Yellowknife Red Cross Hospital opened in February, with the following

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staff: *M. Murphy* (Toronto General Hospital) as matron, and *Dorothy Borisenko* (Holy Cross Hospital, Calgary), *Frances Bailey* (Vancouver General Hospital), *Margaret Drysdale* (Royal Alexandra Hospital, Edmonton), *Mrs. Helen Clark* (Holy Family Hospital, Prince Albert), *Ermeline Neilson*, (Holy Cross Hospital, Calgary), *V. Cloarec* (Holy Cross Hospital, Calgary), and *Betty Price* (Misericordia Hospital, Edmonton).

British Columbia: APPOINTMENTS — *A. J. Dobbie* (St. Eugene's Hospital, Cranbrook), McBride; *L. C. Moffett* (Everett General Hospital, Wash.) to take charge at Edgewood. RESIGNATION — *E. Clark* from McBride. TRANSFER — *E. M. Coulter* from Terrace to Bamfield while *A. Knowlton* in on leave.

New Brunswick: APPOINTMENTS—*Thérèse Arseneau* (Hotel Dieu, Bathurst), Miscou Harbour; *Anita Hudson* (Hotel Dieu, Campbellton), Tobique Valley Hospital, Plaster Rock. RESIGNATION — *Celia Markey* from Kingston Hall Hospital, Rexton. TRANSFER—*Ruby Glencross* from Tobique Valley Hospital to Kingston Hall, Rexton.

Ontario: APPOINTMENTS—*Emily Morgan* (Woodstock General Hospital), Englehart; *Mrs. Marjory Lusk* (Ontario Hospital, London), *Mabel Chisholm* (Guelph General Hospital), and *Mrs. A. Clark*, as nursing assistant, all to New Liskeard; *Bernice Kent* (Brantford General Hospital), Emo; *Delores Metivier* (St. Mary's Training School, Sault Ste. Marie), Thessalon; *Eleanor Gofton* and *Mary Ellis* (both from Kitchener-Waterloo Hospital), Dryden; *Mrs. Edna Halstead* (Brandon General Hospital) and *Josephine Wiggins* (Royal Victoria Hospital, Barrie), Richard's Landing; *June Coles* (Toronto Western Hospital), Hornepayne; *Lea Griffiths* (King College Hospital, London, Eng.), Bracebridge; *Ruth Weekes* and *Ina Forrest* return to staff after several years' absence and are posted to Thessalon and Beardmore; *Mrs. Edith Cooper* as nursing assistant at Haliburton. RESIGNATIONS — *Mabel Allan* from New Liskeard, *Mary Lou Bentain* from Emo, and *Lillian Gerrard* from Red Lake, all to be married; *Mrs. Elma Chester* from Englehart; *I. Baker* from Emo. TRANSFERS AND RELIEF — *Elsie Healey* (Mile End Hospital, London, Eng.) flew to Canada and is spending two months at Mindemoya outpost; *Jean Greenless* (Ballochnyle Hospital, Scotland) relief work at Bracebridge before returning to Scotland; *B. Kent* relief at Emo; *Grace Conroy* from Bracebridge to New Liskeard; *Mary Gibbon* from Port Loring to Callander; *Maud Reesor* from Cal-

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or

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

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lander to Railway Car at Redditt; *Hazel Ball* from New Liskeard to Haliburton; *Dorothy Chapman* from Redditt to Matchewan; *Marie Phillips* from Beardmore to Bracebridge.

Prince Edward Island: *Verna Darrach*, who has been director of Crippled Children's Work since 1946, is now director of Nursing Services.

Quebec: APPOINTMENTS — *Eve Merleau* (Ste. Justine Hospital, Montreal, and McGill University public health course) as director of Nursing Services and *Marcelle Godbout* (B.Sc. in nutrition from McGill) as director of Nutrition Service.

Saskatchewan: RESIGNATIONS—*D. Evans* from Loon Lake to go to the Regina General Hospital; *E. Hockley* from Leoville. TRANSFERS—*M. Roebuck* from sick leave to Hudson Bay; *E. Coughlen* and *A. Barker* from Carragana to Loon Lake; *R. Dulmage* from Hudson Bay to be in charge at Paddockwood; *I. Nessett* from Paddockwood to be in charge at Leoville; *J. More* from Paddockwood to Hudson Bay; *M. Lyle* from Leoville to be in charge at Rockglen; *P. Mitchell* from Rockglen to Hudson Bay.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Jennetta Gillespie* (Hospital for Sick Children, Toronto; University of Toronto certificate course; McGill University advanced course in administration and supervision in public health nursing) as public health nursing supervisor, Halton County health unit, succeeding *Reta Sutcliffe* (H.S.C. and McGill P.H.N. course) who has joined the staff of the Farm Service Force Camps, Y.W.C.A., as nursing supervisor; *Oleavia Chant* (Buffalo City Hospital and U. of T. certificate course) formerly with Halton County health unit, St. Mary's Board of Health; *Lettie (Price) Fairley* (Children's Hospital, Buffalo, and Ontario Department of Education school nursing summer course) Fort Erie Board of Health, and *Margare, Philps* (Buffalo General Hospital and Ont. Dept. of Educ. school nursing summer course), Bertie Township Board of Health — both nurses formerly employed by Welland County School Medical Inspection Committee; *Marian Hatcher* (Royal Victoria Hospital, Montreal, and U. of T. certificate course), Galt Board of Health.

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Here is a mild, yet thorough, laxative combining the *plus* properties of an effective antacid to aid in relieving constipation and gastric hyperacidity.

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2 to 4 tablespoonfuls
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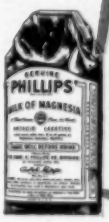

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Nursing Sisters' Association

At the annual meeting of the *Montreal Unit* the following officers were re-elected: President, N. Kennedy-Reid, matron, Ste. Anne's Hospital; vice-president, Ida Henderson, matron, Queen Mary Veterans Hospital; treasurer, Mrs. C. E. Bisaillon. E. Johnson was elected secretary and I. M. Murphy, convener of the Social Activities Committee. Ida Henderson will act on the Rehabilitation Committee. The convener of the Visiting Committee is Mrs. J. A. Toller, assisted by M. Wright, E. Cumbers, M. desRosiers.

News Notes

ALBERTA

CALGARY:

A recent meeting of the Calgary General Hospital Alumnae Association was in the form of a Valentine party in honor of the class of 1948. After a short business meeting the fun began. Two graduates had to design and make a dress from crepe paper for the graduating nurse. Many novel ideas came to light, introducing the "new look." Prizes were given for the best costume and an enjoyable evening was spent by all. Refreshments were served by Mrs. B. C. White and her committee.

EDMONTON:

Royal Alexandra Hospital:

The alumnae association is offering a scholarship of $250 for a university course or $125 for a hospital course. Any graduate of the school, in good standing in her alumnae, is eligible to apply. Applications must be in the hands of the convener by *May 1* and forms may be obtained by writing to Miss Violet Chapman at the hospital.

BRITISH COLUMBIA

GREATER VANCOUVER DISTRICT:

Mrs. Frank Stead, chairman of the Volunteer Bureau of Greater Vancouver, was guest speaker at the annual meeting of the Greater Vancouver District Association, held at St. Paul's Hospital. Mrs. Stead presented in an interesting way the community needs and a list of some of the activities for which volunteers are needed. Interesting reports of chapters and committees were presented in printed form to each member and additional copies sent out to nursing centres.

P. Capelle, on behalf of the members, presented the retiring president, J. E. Jamieson, with a corsage and expressed appreciation for her leadership as president.

St. Paul's Hospital:

The Homecoming, held on February 10 at the nurses' home, was attended by some 250 enthusiastic and hungry S.P.H. graduates. As this was about a hundred more than were expected, some slight congestion occurred but everyone received in due course an ex-

NURSING

By Lulu K. Wolf, Professor of Nursing, Vanderbilt University School of Nursing. This new nursing textbook deals not only with bedside nursing techniques, but with training the patient for future health. 534 pages. 201 illustrations. 1947. $4.00.

ESSENTIALS OF OBSTETRICS

By Henry L. Woodward and Bernice Gardner, Cincinnati, Ohio. A clear, logical and interesting discussion of obstetric management and nursing care. Includes sections on vitamins, convalescence, oil and sun baths and nephritic and hypertensive toxemias. 733 pages. 369 illustrations. 1944. $4.00.

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The Cake in the Non-Rust Tin

cellent turkey dinner and did it full justice. The earliest graduate present was the new Sr. Superior, Sr. Teresina, a member of the class of 1912 — the latest, the class of 1948, who were guests. Some of the highlights — Mrs. Dawe's account of the time Sr. Teresina, as a student nurse, climbed up the inside of the chimney of the present building, then under construction, to look out of the top, and had a difficult time getting down again! Also welcomed by old friends was a group who motored up from Seattle, including Dorothy (Bird) Kelley, Sidney (Jarvis) Berry, J. (Brasell) Knippel, and Bernice Nelems, who owns her own 20-bed hospital in Seattle.

The alumnae, with all members of St. Paul's staff, extends its congratulations to M. Stanley on her twenty-fifth anniversary at the switchboard of St. Paul's and marked the occasion by presenting her with a silver compact, a very small recognition of the fact that the whole hospital functions more smoothly because of her efficient discharge of her duties at the telephone exchange.

Following the convention in June, Sr. Columkille plans a trip to England.

Vancouver General Hospital:

The following are enrolled for the four-month post-graduate course in surgery: Florence Halliwell (Regina General Hospital); Helen Kreblewetz and Muriel Coslik (both of Grace Hospital, Winnipeg); Rosemary Goldstone (Royal Columbian Hospital, New Westminster); Margaret Hunter (Royal Victoria Hospital, Montreal); Marion Steeves (St. Boniface Hospital, Man.); Ethel Down (Saskatoon City Hospital); Nellie Lees (Grey Nuns' Hospital, Regina).

WEST KOOTENAY DISTRICT:

A district executive committee meeting was held recently in Trail at the home of the president, Mrs. W. Miller. Associate membership fees were discussed and it was suggested that those for Nelson Chapter should be fifty cents instead of one dollar. A letter was sent to Alice Wright, registrar, R.N.A.B.C., indicating that Nelson, Trail, and Rossland would stay together, but would be pleased to accept Grand Forks and Greenwood. Fifteen dollars was donated to the War Memorial Fund. F. A. Kennedy gave the treasurer's report, revealing a balance of $59.04. It was agreed that the present executive remain in office for a second term. It consists of: President, Mrs. W. Miller, Trail; vice-president and councillor, F. McLean, Rossland; secretary, Mrs. M. Miller, Nelson; treasurer, F. A. Kennedy, Rossland; public health, N. Lee, Nelson.

CHILLIWACK:

The annual meeting of Chilliwack Chapter was held recently when the following officers were elected: President, Mrs. G. Roberts; vice-president, Mrs. E. Davis; secretary-treasurer, Mrs. N. McGregor; committees: program, M. Zink; membership, Misses McMichael, A. McKay, Mmes Bibby, Webb;

ways and means, A. Wiens; visiting, Mrs. J. Barker; representatives to: press and publications, K. Crowley; *The Canadian Nurse*, Miss Rogers.

Financially, 1947 was a successful year for the chapter, the tea and rummage sale raising substantial sums. The chapter was thus able to contribute $50 to the War Memorial Fund, keep a special emergency fund going, pay a private nurse for needy cases, and send parcels overseas.

This year the members will "adopt" a European child and contribute to its support, and also help to furnish a nurses' sitting room at the General Hospital. Parcels will still go to nurses in England.

Regret was expressed at the departure of the president, C. Bratrud, for Red Deer, and the chapter was also sorry to lose the secretary-treasurer, E. Morton, who changed her position. However, it was a pleasure to welcome Miss Orton, the new matron at the General Hospital, and Mrs. Porteous, assistant matron, as new members.

CRANBROOK:

The annual meeting of Cranbrook Chapter was held recently with the president, Mrs. A. B. Smith, in the chair. The officers elected included: President, Mrs. E. Rendle; vice-president, Rev. Sr. Denise Marguerite; secretary-treasurer, M. Abernethy; program committee, Mrs. A. McCrae; social committee, Mrs. P. Webster. The guest speaker was Mrs. Marion Miles Pennington who gave an interesting account of her work in Europe with UNRRA.

Mr. John Murrell, sanitarian for East Kootenay health unit, addressed the members on Cranbrook's domestic water supply at a well-attended regular meeting. Isabel Dunlop was elected delegate to the R.N.A. B.C. annual convention.

KAMLOOPS-TRANQUILLE:

Dr. Wm. Trapp spoke to a large gathering of nurses at a recent meeting of Kamloops-Tranquille Chapter on "Chest Surgery," demonstrating his interesting lecture with x-ray films. During the business session, the president, Mrs. R. Waugh, was elected delegate to the provincial annual meeting to be held in Victoria.

A pretty setting at the Central Hotel featured the chapter's annual Valentine Tea. The event was well supported by the people of Kamloops, the following proceeds being netted: homecooking, $41.25; candy stall, $44.35; raffle, $235. Generous donations brought the grand total to around $471 which will be used for charitable causes. Mrs. J. J. Pattinson was the convener for the gift certificate sale and Mrs. H. Hopgood donated the cake to be raffled. The homecooking sale was convened by Mrs. D. A. B. McPherson and Mrs. C. Farquharson was in charge of the candy booth. Mrs. Ross Dalgleish ably took charge of the tearoom, assisted by H. MacKay, O. Clancy, Mmes A. M. Tyrrell and E. Ransome. Delightful entertainment was

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Registered Nurses without public health preparation will be considered for temporary employment.

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The room in the new wing of the Royal Inland Hospital, furnished by the nurses, is now complete with turquoise blue furniture, radio, standard lamp, and matching bed "throw."

PENTICTON:

Thirty-two members were present at a recent regular meeting of Penticton Chapter. Mrs. E. Boulding presented the report from the annual Red Cross meeting and Mrs. L. Traviss sent a letter of thanks to those nurses who had assisted at the Blood Donor Clinic.

The guest speaker was Marcel Ker-Ramsay from London, England. Miss Ker-Ramsay, who is sister-tutor at St. Bartholomew's Hospital, London, gave a talk on "Nursing in the British Isles." She stated that nursing over there is in the transitional stage as they are still about twenty thousand nurses short. In order to make the profession more attractive, hours of work are being lessened and salaries raised. Miss Ker-Ramsay pointed out that the National Health Bill, if passed, will change nursing in its administrative departments to quite an extent and that nurses will assume the status of civil servants. Two advantages the British nurses have are inclusion under the Health Insurance Scheme and superannuation at fifty-five. After giving a description of types of training which British nurses may undertake and requirements for entry, wages, etc., the speaker concluded with a few words on St. Bartholomew's, which is the oldest hospital in the world, being founded in 1123 A.D.

The ticket convener for the successful Valentine Dance was Mrs. L. W. Pigeau while Mrs. H. Ackerman was in charge of refreshments. R. Wylie supervised the decorations. Mrs. Pigeau attended the R.N.A.B.C. annual meeting as councillor from Kamloops-Okanagan District while Mrs. G. R. Leonard represented the chapter.

MANITOBA

BRANDON:

At a meeting of the Brandon Association of Graduate Nurses the members were entertained by films shown by Mr. R. M. Coleman. Marion Patterson presided at the brief business meeting while Mrs. J. Selbie's group took charge of refreshments.

General Hospital:

A recent meeting of the staff graduates took the form of a party when games and refreshments were enjoyed by all. Several nurses gave informative talks on new drugs, following the monthly graduate staff dinner held in January.

NEW BRUNSWICK

MONCTON:

Mrs. Roberta Perry, the president of the Moncton Chapter, was in the chair at a recent meeting. Letters of thanks were read for Christmas donations. Parcels are going

regularly to a British nurse. Mrs. Nash-Smith reported on the executive meeting held in Saint John with the Practical Nurses Association. Our association has accepted different recommendations for general registry rules and these will be forwarded to Saint John for approval. A letter of regret was sent to Miss MacMaster, provincial executive member, on her departure from the city. Mrs. Perry was appointed to replace Miss MacMaster on the provincial executive.

The guest speaker was Dr. Ralph Fitch who took as his subject "The Premature Child." Dr. Fitch discussed the psychological handicaps, clinical consideration, and care of the premature child.

SAINT JOHN:

Bessie Seaman, the president, was in the chair at a recent meeting of Saint John Chapter. The chief topic of the evening was the C.N.A. biennial meeting to be held in Sackville from June 28 to July 1. Motion pictures of skiing in the Rockies, and by the sea in Nova Scotia and New Brunswick were enjoyed by the members.

General Hospital:

The annual meeting of the alumnae association was held recently with Beatrice Selfridge, the president, in the chair. Reports revealed that 1947 was a very successful year for the chapter, more members taking an interest in the activities. Two interesting letters from English nurses were received both expressing appreciation for boxes forwarded. Kathleen Bell and Alberta Hanscome volunteered to pack the next boxes.

Miss Selfridge was re-elected as president for 1948, with M. Scott and A. Hanscome as vice-presidents. Audrey Ross is secretary with Mrs. W. Bambury her assistant. The treasurer is Mrs. E. Handren.

An old-fashioned sleigh drive was enjoyed by the junior division of the senior class of the training school. Following the drive, a dinner and dance were held rounding out an evening of fun.

On the eve of their arrival, the new "proby" class was entertained by the "proby" class preceding them.

Lancaster Hospital:

The Lancaster Hospital Nurses' Association gave an enjoyable bridge when sixteen tables were required to accommodate the guests. Prizes were won by E. McQuade, L. Belding, and K. Whipple. Evelyn Abbott was the convener of the committee in charge of arrangements, assisted by Mrs. H. Maxwell, E. Green, and E. Price. Decorations were in keeping with St. Valentine's Day.

St. Joseph's Hospital:

A recent meeting of the alumnae association took the form of a well-attended social evening. A box of food was packed for the "adopted" family in Britain. A letter was read from the family, expressing apprecia-

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Session 1948-49

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Nursing Education: Advanced (a course organized for those preparing for senior administrative work in nursing schools).

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Public Health Nursing: Advanced courses in Administration and Supervision, or other specialty.

Clinical Supervision in:
(a) Medicine
(b) Surgery
(c) Obstetrics
(d) Paediatrics
(e) Operating-room procedure
(f) Tuberculosis or other specialty as selected.

Note: In Clinical Supervision the student chooses one of the above as her field of study for the entire year.

III. **A Special Arrangement for Graduate Nurses:** Whereas a candidate with Senior Matriculation standing may register in the Faculty of Arts of this University and complete the Pass course in Arts in 3 years, and, whereas some of the subjects of this Pass course in Arts are identical with certain subjects included in the above Certificate courses, it has been arranged that a graduate nurse who registers in this Pass course in the Arts Faculty may register at the same time in this School and, during the same 3 years, cover the requirements for the Certificate in one of the courses as described above, except that the courses in Clinical Supervision are not included in this arrangement.

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McGILL UNIVERSITY, MONTREAL 25

tion of these valuable gifts. Clothing is also to be forwarded to them in the future.

Valerie Moffard and Marjorie Parsons are now on the staff of the Montreal General Hospital and Ethel McGowan is with the Community Hospital, Wisconsin. Frances Dionne is doing general duty at St. Joseph's Hospital, Washington, and Madeline Wakim is in Toronto doing private duty.

ST. STEPHEN:

A recent meeting of St. Stephen Chapter took the form of a card party held at the home of Clara Dowling, when prizes were won by M. Brownrigg, Mmes H. Lawrence and McGarrity. G. Rutherford, of Calais, was the winner of nylon stockings, the drawing for which was in aid of the War Memorial Fund. A pair of blankets was the gift of the chapter to the Rest-Breaks Home in England and the acknowledgement for them was read by Mrs. R. Rogers. The members contributed yarn from which Jane Cunningham made an afghan, also to be sent to the home. Mrs. C. Anderson volunteered to send the next food parcel for the chapter to the British nurses, and Clara Boyd for the Chipman Memorial Hospital Alumnae Association. The previous parcels had been prepared by Mmes L. O'Brien and H. Lawrence.

In the absence of K. Vaugh, Melva Marsh is supervising the C.M.H. operating-room. Doreen Thurlow is now on the staff of the newly opened Red Cross Hospital at Harvey.

ONTARIO

DISTRICT 1

CHATHAM:

Mrs. Elsie Cripps was elected president of the Public General Hospital Alumnae Association at the annual meeting. The vice-presidents are E. Stenton and A. McKenzie, with Mrs. Anne Stoehr and Ann Hastings serving as recording and corresponding secretaries. The treasurer is D. Thomas. Excellent reports were given, revealing an active year. A miscellaneous shower of food, soap and clothing was collected to send to a British nurse. Food parcels were also forwarded to another nurse, assigned by the district to the alumnae.

DISTRICTS 2 & 3

BRANTFORD:

At a recent meeting, the Brantford General Hospital Alumnae Association entertained the nurses of Brantford and district who have trained in other hospitals. Gay Valentine decorations lent a festive air to the occasion. Olive Plumstead, the president, was in charge of registration and welcomed the guests.

The guest speaker was Dr. George Yang, who has been doing post-graduate work at the hospital for the past few months. A graduate in medicine of Cheelwo University, China, Dr. Yang served with an ambulance unit for four years on the Burma Road and in northern China. In 1945 he worked with

Rae Isaac, a B.G.H. graduate and a United Church missionary. Dr. Yang spoke of the geography, language, and customs of his homeland as well as its history and present-day medical facilities. He was introduced by Ailsa Scott and thanked by Norma Johnson.

An enjoyable sing-song was led by Mary Terryberry, with piano accompaniment by Dorothy Smith. Mrs. Florence Hanna won the lucky chair prize. Games were conducted by Miss Johnson, convener for the evening. Refreshments were served by Mmes L. Sheppard and G. Thompson, assisted by several members of the class of 1946.

Margaret Pickersgill has returned to her position as supervisor of the operating-room after three months' post-graduate work in Montreal.

District 4

Hamilton General Hospital:

The executive committee of the Hamilton General Hospital Alumnae Association is pleased to announce that the Dr. Walter F. Langrill Educational Fund is ready to function. One thousand dollars has been established, the nucleus of which was a legacy. The balance was raised by individual and combined efforts of the members.

The purpose of this fund is to assist nurses to extend their education by taking post-graduate courses in specialized fields of nursing, including university refresher courses, credits towards degrees, economics, human relations, and business administration. The applicants must be members of the alumnae association. The most worthy applicant shall be decided by the administering committee. The fund shall be maintained by voluntary subscriptions from the alumnae members and their friends. The maximum amount available at present is $250. The convener of the committee to govern the fund is Ada Scheifele, superintendent of nurses at Mt. Hamilton Hospital.

It is hoped that older members of the alumnae, as well as new graduates, will avail themselves of this educational opportunity.

Ellen Callander, a 1936 H.G.H. graduate, was the guest speaker at a recent meeting of the alumnae. She gave an interesting talk on her experiences as a medical missionary in South America from 1937 until 1945. Miss Callander is hoping to return to South America this year.

District 6

PETERBOROUGH:

December 8, 1947, was a day long to be remembered in the history of St. Joseph's Hospital, as it marked the occasion of the formal opening and dedication of the new nurses' residence and school of nursing. The ceremonies began with the celebration of Mass by His Excellency, Most Rev. J. Gerald Berry, Bishop of Peterborough. Sisters, nurses, and friends gathered in the beautiful auditorium which formed the setting for this momentous occasion. Appropriate hymns

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A3

MENTHOLATUM

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were sung by the Sisters' choir of the Mother House, Mt. St. Joseph.

At the close of Mass, His Excellency addressed the assembly, first paying tribute to those Sisters who, fifty years ago, established the first hospital on this hill. Their courage and patience in the face of great difficulties have made possible this present institution. He urged the nurses to appreciate their heritage, the beautiful spacious school with its fine equipment, and residence with its homelike atmosphere. In its halls they will receive training for the great profession which they have chosen. His Excellency stressed the fact, however, that it is in the hospital proper, at the sick bed, that the nurse receives the real training which will reveal and develop the womanly characteristics essential to a nurse. She will learn there to bring to those in her care comfort of body and mind.

His Excellency's concluding thought was that this great undertaking is an expression of the trust which the Sisters of St. Joseph place in the future of Canada, and it is the nurses who will justify this confidence by their spirit of co-operation, loyalty, and zeal.

PRINCE EDWARD ISLAND

At the last quarterly meeting of the Prince Edward Island Registered Nurses Association, the president, Mrs. Lois MacDonald, paid tribute to Margaret Leard, one of the members, whose untimely death brought sorrow to her many friends and associates—

"Margo, when needed, was most willing to give of her best, and it was always a delight to hear her music. Her last contribution to the P.E.I.R.N.A. was given at the annual meeting in June, 1947.

"Her tragic passing brings to each and every one of us the uncertainty of life and we need take cognizance of this fact. In respect and love to her memory let us rise and observe a minute of prayerful silence."

Marion MacKinnon, Della Moore, and Freda MacInnis are practising their profession in Alberta, while Mabel Keizer is in New Jersey, U.S.A.

QUEBEC

MONTREAL:

General Hospital:

"Fenestration Operation for Otosclerosis" was the subject of Dr. Ernest Scharfe's instructive talk to the members of the Montreal General Hospital Alumnae Association at a well-attended meeting. His outline included the anatomy of the ear and reasons for operation, patients in which the operation was of advantage, pre- and post-operative treatment and nursing care, return of hearing, and beneficial results obtained in restoring hearing. The first vice-president, N. Kennedy-Reid, who presided, thanked the speaker.

Agnes Rodger has resigned from the staff of the Western Division after many years' valuable service. Miss Rodger was in charge of the fifth floor, private patients' pavilion.

The supervisor of the division, B. Birch, entertained at a buffet supper in her honor and she was presented with a gift by the nursing staff prior to her departure.

Recent graduates accepting positions as general staff nurses at the Western Division include Edna Baird, Joan Telford, Ruth Meyers, Jean Bothwell, and Ileana Norman.

Royal Victoria Hospital:

Dr. Martin Hoffman gave an interesting lecture on "The Endocrine Glands" at a well-attended meeting of the Royal Victoria Hospital Alumnae Association. At a meeting of the Institutional Nursing Section held at the Neurological Institute, Dr. W. Penfield addressed the members on "The Neurosurgeon and the Nurse."

Helen Schurman is now superintendent of nurses at the Victoria Public Hospital, Fredericton, N.B. (See Nursing Profiles this issue.) Mabel Darville has rejoined the staff of the Neurological Institute and is in the operating-room. Evelyn Wade is enrolled in a course for medical librarians at Kingston, Ont. Lois Frood, of the Ottawa Civic Hospital staff, was a recent visitor to the school.

SASKATCHEWAN

MOOSE JAW:

The draw for the tailored suit, sponsored by Moose Jaw Chapter, took place recently when court whist was enjoyed and lunch served.

Providence Hospital:

Betty Backes is on the General Hospital staff at Moosomin, Sask. Mrs. K. A. Cameron, former matron of Freemason Hospital, Morden, Man., is O.R. nurse at Selkirk, Man. Hazel Wynne Jones, who has completed a post-graduate course in surgery at the Vancouver General Hospital, is now staff nurse at Emory University Hospital, Georgia. F. O. Hughes, former O.R. supervisor at the General Hospital, Port Alberni, B.C., is taking a course in surgery at the Vancouver General Hospital. Ann Tymko, formerly of the Welland County General Hospital, Ont., is taking a course at the New York Polyclinic. Mrs. F. Crosbie, formerly of Kingston, Ont., has returned to Moose Jaw. Mrs. O. Boyle, formerly of Expanse, has also returned to the city.

REGINA:

Dr. Florence Haslam, medical missionary from the Punjab, India, was guest speaker at a recent meeting of Regina Chapter. Attired in a beautiful sari, in her charming and witty manner she told of her life and experiences in India.

General Hospital:

Recent graduates who have joined the general staff include: A. Hobbs, G. Robertson, G. Wilke, W. Wilkins, D. Ferrier, J. Findlay, M. Warren, M. Huyck, F. Bell, and D. Newbatt. M. O'Brien, an Ottawa Civic Hospital graduate, is also on the general staff.

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REGISTRATION OF NURSES

Province of Ontario

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EXAMINATION ANNOUNCEMENT

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An examination for the Registration of Nurses in the Province of Ontario will be held on **May 19, 20 and 21.**

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

The Director,
Division of Nurses Registration
Parliament Buildings, Toronto 2

THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

SCHOLARSHIPS FOR SEASON, 1948-49

The Committee of Management of The Association of Nurses of the Province of Quebec is pleased to announce that two scholarships, known as the Jeanne Mance Scholarship, will be awarded this year, covering $500 each, to English- and French-speaking members in good standing in the Association, wishing to follow post-graduate courses.

Application forms may be obtained at the office of the Association,

504 MEDICAL ARTS BLDG.,
1538 SHERBROOKE ST. W.
MONTREAL 25,

and must be returned completed before *June 1, 1948.*

E. FRANCES UPTON, R.N.
SECRETARY-REGISTRAR

REGISTERED NURSES' ASSOC'N. OF BRITISH COLUMBIA
Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director
Placement Service
1001 Vancouver Block, Vancouver B.C.

Grey Nuns' Hospital:

The new Sacred Heart Wing was opened on February 1. The capping exercises for the preliminary students of September, 1947, took place recently. The alumnae association entertained members of the Regina General Hospital Alumnae Association and staffs of both hospitals at a skating party. At the conclusion of this enjoyable event, everyone returned to the nurses' residence for lunch.

Mary Taber is now laboratory technician at Unity Hospital.

SASKATOON:

City Hospital:

The alumnae association recently held their annual membership tea when the guests were welcomed by the honorary president, Mrs. J. E. Porteous, and the president, M. R. Chisholm. Four food parcels a month are being sent to British nurses for which many letters of appreciation have been received. Letters of thanks were read from Melfort nurses for the aid given after the recent fire there. Honors at the tea table were performed by Mmes S. Hayward and H. Gilding. Out of town guests were Mrs. J. Rake of New York and Mrs. C. Stalker of Prince Albert. B. Haver was in charge of the evening's entertainment which included a musical program.

At a candlelight ceremony, forty students of the class of 1950 received their caps. The students contributed their talent to the musical part of the program, and lunch concluded an enjoyable occasion.

A tea, held by the nursing students, proved a successful event.

Elizabeth Health has replaced Mrs. B. Jensen, who has resigned, as supervisor of emergency. D. Bell is now on the operating-room staff. Mrs. B. Logan has resigned from the staff to join the cancer clinic.

St. Paul's Hospital:

St. Paul's is pleased to welcome Dr. Buckwold, a specialist in pediatrics, who returned to Saskatoon after taking a post-graduate course in London, Eng. He worked there in a children's hospital for a considerable length of time. Greetings are also extended to Dr. Upthegrove, a qualified anesthetist from Montreal, who is now on the staff.

Forty happy Freshmen B recently received their caps and took their places in the school as the new Freshmen A class. Nineteen new students replaced them. A lovely welcome party was held in their honor, when the faculty, as well as the students, enjoyed the evening.

SWIFT CURRENT:

Four nurses from Health Region No. 1 — J. Cloarec, I. Paton, E. Randall, and L. Miller — attended a special course in mental hygiene held at the Saskatchewan Training School, Weyburn.

Mrs. V. Steeves, a graduate of Grace Maternity Hospital, Halifax, is welcomed to Swift Current.

WEYBURN:

An address on "Social Welfare Work" was given by E. Carson, child welfare worker, at a regular meeting of Weyburn Chapter. On behalf of the chapter, M. MacDonald held a tea in honor of K. W. Ellis, registrar, S.R.N.A., who was a visitor at the Saskatchewan Training School. The chapter is pleased to welcome three new members — Helen Campbell, G. Fitzpatrick, superintendent of nurses, Saskatchewan Training School, and J. Heinrick, nursing instructor, S.T.S.

The following public health nurses attended the course in community psychiatry held at the Saskatchewan Training School: Misses Armstrong, Anderson, Mitchell, Gall, McIntyre, and Brett.

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There are vacancies on the Graduate Staff of the **Nova Scotia Sanatorium, Kentville, N.S.** for qualified Nurses. *Salary* starts at $95.00 per month plus full maintenance. Good hours with excellent working facilities and living accommodation. Opportunities for advancement. Appointments carry holiday, sick leave, and superannuation benefits of the Civil Service.

Application forms may be obtained from the: **Nova Scotia Civil Service Commission, P.O. Box 943, Halifax, N.S. or by telephoning No. 3-7341-Branch 230.**

Supt. of Nurses for large General Hospital with School for Nurses averaging 150 students. Applicants should give full details of education, post-graduate training, experience, references, etc. Correspondence invited. Apply in care of Box 3, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Director of Educational Program. A new development of the General Hospital, Kingston, Ontario, makes possible this vacancy. Applicants should give full information of training and experience. Apply to Supt. of Nurses.

Qualified Registered Nurse as Instructor for 150-bed General Hospital. 75 students. Duties to commence Sept. Salary: $150 per month plus $30 maintenance. Apply, stating qualifications, experience, age, religion, to Supt. of Nurses, General Hospital, Chatham, Ont.

Supervisors (3) — Health, Medical, Private Wards. Salary if living in $140 plus maintenance; if living out $165 plus meals. Good scope for teaching ability. **Administrative Assistant** also required. Apply, stating qualifications, experience, references, when services available, in care of Box 4, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Scrub Nurse for **Operating-Room** for 220-bed Tuberculosis Sanatorium. Salary: $150 gross, less $30 for maintenance, laundry. 8-hr. day, 6-day week. 3 weeks' annual vacation. Sick leave. Pension plan. Excellent living accommodation. Apply to Supt. of Nurses, Fort William Sanatorium, Fort William, Ontario.

District Nurse in Province of Alberta. Rural service: Emergency treatment, preventive and maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $1,920-$2,400. Sick leave, annual vacation, superannuation. Apply to Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

Graduate Nurse for **General Staff Duty** for 350-bed Tuberculosis Hospital. Starting salary: $110 per month plus full maintenance. Apply to Miss C. Louise Bartsch, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Graduate Staff Nurses for modern 120-bed hospital, fully approved. 60 miles from New York City. Salary range: $2,100-$2,400. Vacation, sick time, 10 holidays, 48-hr. week. Added compensation for evening and night duty. Salary increase every six months. Attractive residence facilities available if desired. Apply to Director of Nursing, Horton Memorial Hospital, Middletown, New York.

General Staff Nurses interested in February ad re Ladysmith (B.C.) General Hospital will be glad to learn salary raised to $155 per month gross; $35 deducted for full maintenance. Apply to Miss D. Behrendt, Matron.

General Staff Nurses (Registered). Initial salary: $76.20 bi-weekly. Increment at the end of 1st and 2nd years of service. 3 weeks' annual vacation. 6-day (48-hour) week. Sick leave—1 day per month—accumulative. Pension Plan. Excellent living accommodation. Apply to Supt. of Nurses, Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont.

Graduate Nurses for completely modern West Coast hospital. All-graduate staff. Commencing salary: $150 per month, less $25.00 for board, residence, laundry. 44-hour week. 1 month's vacation with pay after 1 year's service. Transportation allowance not exceeding $60.00 refunded at end of 12 months. Apply, stating experience, to Matron, General Hospital, Prince Rupert, B.C.

Graduate, Registered Nurses for Medical & Surgical hospital for specialized work. Staff duty, 44-hour week, straight 8-hour day. Attractive salary, with additional compensation for 3-11 and 11-7 duty. Uniforms laundered free. Cafeteria meal service. Living quarters available in hospital annex. Apply to Personnel Office, Cleveland Clinic Foundation, 2020 East 93rd St., Cleveland 6, Ohio.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock, and Toronto Psychiatric Hospital. Initial salary: $1,740 per annum, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 weeks' vacation, statutory holidays, special holidays, 8-hour day, 6-day week. Apply to Supt. of Nurses at above hospitals.

General Staff Nurses. 44-hour week. Gross salary: $155 plus laundry, with increases. Extra $5.00 all night rotation shifts. All perquisites. Registration in British Columbia essential. Apply to Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Graduate, Registered Nurse for **Floor Duty.** Salary: $100 per month; full maintenance; increase of $5.00 per month after 1 year's service, up to 3 years. 8-hour duty. Blue Cross Hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Qualified Dietitian for General Hospital. Good salary and full maintenance. Apply to Administrator, General & Marine Hospital, Owen Sound, Ont.

Registered Nurse for Ward Supervision. Also Nurses for General Duty. 100-bed General Hospital in Western Ontario. 8-hour day and 6-day week. Apply, stating qualifications, experience, salary expected, and date available, to Administrator, General Hospital, Woodstock, Ont.

Instructor of Nurses. New school, well equipped. Duties to commence in July. Apply, stating age, qualifications, experience, salary expected, to Director, School of Nursing, General Hospital, Galt, Ont.

Supervisors (2) for Ward Administration and to assist with Ward Teaching of students. Apply, stating age, qualifications, experience, salary expected, to Director, School of Nursing, General Hospital, Galt, Ont.

Nurses Arts & Science Instructors to commence classes Sept. 1. State qualifications, date available in first letter. Apply Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Registered Nurses with Psychiatric experience immediately for active treatment 1500-bed Psychiatric Hospital, conducting accredited School of Nursing. Straight 8-hr. day, 6-day week, 31 days' vacation annually with pay. Excellent living accommodation. Gross salary: $155 monthly. Annual increases. Maintenance $30. Uniforms provided. Apply Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Night Supervisor, Assistant Night Supervisor, & Obstetrical Supervisor for 130-bed hospital. Apply, stating qualifications, salary expected, when available, to Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses for Municipal Hospital in city of 5,000, situated in Central Alberta close to popular summer resort & main cities. 65 beds under direction of Supt. 8-hr. shifts. 6-day wk. 3 wks' annual vacation with pay at end of 1 yr; prior vacations may be arranged. Commencing salary: $110 monthly with full maintenance; increased to $115 at end of 6 months & to $120 at end of 12 months. Apply, stating age, marital status, experience, to Nursing Supt., Municipal Hospital, Red Deer, Alta.

General Duty Nurses (3) for 110-bed hospital in British Columbia. 48-hour wk. 4 wks' holiday after 1 year's service & all statutory holidays. Salary: $140 plus yearly increment, less part or all maintenance as required. Apply Supt. of Nurses, Nanaimo Hospital, Nanaimo, B.C.

Public Health Nurses (2) for Bruce County Health Unit. Salary: $1,800 minimum, depending upon experience. Car supplied if desired. Mileage allowance if own car used. Apply, stating experience, etc., to Miss Florence Greenaway, Walkerton, Ont.

Graduate Nurses for General Staff. Modern 107-bed hospital. 8-hour shifts, 6-day week, sick time. 1 month's holiday after 1 year's service. Apply Miss Elizabeth McEachren, Supt., Kirkland & District Hospital, Kirkland Lake, Ont.

Supervisor for Medical & Surgical Ward. Duties commence May 1. Gross starting salary: $170 with increases according to qualifications. Apply Director of Nursing, Kitchener-Waterloo Hospital, Kitchener, Ont.

General Duty Nurses for 80-bed General Hospital: Salary: $115 per month (including pay for O.R. call & bonus) plus maintenance. Increase at end of 6 months to $120 & at end of 1 year to $125. 8-hr. day, 6-day wk. 2 wks. holiday with pay (3 wks. given at end of 2nd yr). Allowance for sick leave, hospitalization, statutory holidays. Additional $5.00 per month for 3:30 shifts. Apply, stating qualifications, date available, to Supt., Norfolk General Hospital, Simcoe, Ont.

Instructor & Clinical Supervisor for Training School of 43 students at General Hospital, Port Arthur, Ont. 150-bed hospital, being increased to 250 by new wing. Salaries open. Full maintenance provided. 8-hr. day, 6-day wk. 1 month's vacation with pay after working 1 yr. Apply, stating qualifications, salary required, to Supt. of Nurses.

Registered Nurses having good Clinical experience for **Visiting Nurse** in rural communities in New Brunswick. Public Health course preferred. Living quarters provided; also office where ambulatory patients may call for advice & treatments. Work also includes bedside nursing in homes. For further information apply Supervisor, Outpost Hospital & Nursing Services, New Brunswick Division, Canadian Red Cross Society, 66 Prince William St., Saint John, N.B.

General Duty Nurses for Joyce Memorial Hospital, Shawinigan Falls, Quebec. 42 beds. 8-hour shift. Salary: $32.50 per wk, day duty; $34.50 afternoon & night duty. 8 statutory holidays. 15 days' vacation with pay. Increase in pay after 1 yr. Apply to Supt. of hospital.

Role of Health Education

The health educator being somewhat of a newcomer to the ranks of professional public health workers, it is not surprising that the nature of his job is often not too clear to those with whom he must work. For those who desire a better understanding of the subject, a recent article by Mayhew Derryberry, Chief of the U.S. Public Health Service Office of Health Education, should be welcome news. The title of the paper, "The Role of Health Education in a Public Health Program," gives some idea of the scope of information presented. The main points of Dr. Derryberry's remarks are:

"All progress in public health requires education. When the problem is to provide a community facility or to improve some universally used product, as the water supply, education of a majority of the people may result in the necessary legislation, authority, or funds.

"Many diseases, however, can be controlled only through the intelligent action of all the people. The task of health education is to stimulate that action. Psychological, economic, and social barriers exist which make the task difficult.

"A wide variety of resources, tools, and methods are available, however, to overcome the difficulties and to accomplish the task. These include mass information, the schools, and community leaders of all types. Each of these resources has its own limitations; a planned co-ordination of all resources is needed for effective health education.

"The development that gives greatest promise at the present time is the trained public health educator in a local health department, whose specific task is to bring about this co-ordination of all community resources for the improvement of individual and community health."

Polio Care Expensive

Poliomyelitis is one of the most expensive diseases known to medical science, reports the National Foundation for Infantile Paralysis. A respirator case may require 24-hour nursing care and cost as much as $10,000 per year. The average cost of a polio case today is estimated at $2,000.

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

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COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Committee on Institutional Nursing; (3) Chairman, Committee on Public Health Nursing; (4) Chairman, Committee on Private Duty Nursing.

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Manitoba: (1) Miss I. Barton, Veterans' Home, Winnipeg; (2) Miss V. Williams, St. Boniface Hospital; (3) Miss D. Dick, City Health Dept., Winnipeg; (4) Miss M. Muir, 16 Gordon Apts., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie, St. Joseph's Hospital, Saint John; (3) Miss M. Clark, 285 Germain St., Saint John; (4) Mrs. B. Nash Smith, 57 Queen St., Moncton.

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